THE ALPHABET SOUP OF MEDICARE AND MEDICAID CONTRACTORS

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Introduction

Healthcare providers, suppliers, and their staff, as well as attorneys representing healthcare entities are faced regularly with a barrage of private contractors tasked with a variety of responsibilities for administering the Medicare program, including claims processing, reimbursement, enrollment and auditing activities. Given the number of different contractors (and different acronyms, for that matter), it can be difficult to identify the role of the particular contractor one is dealing with, the focus or goal of the program the contractor is involved in and the responsibilities it is tasked with managing, as well as the statutory and regulatory scope of its authority. This article seeks to identify the various Medicare and Medicaid contractors and outline their authority, focus and responsibilities.

Medicare Contractors

Contracting with private entities has been a part of the Medicare program since its inception. When Medicare was enacted in 1965, there were concerns over the government’s intrusion into the healthcare affairs of Americans, so Congress provided for the Medicare program to be administered primarily by private entities that were already engaged in the health insurance business. Section 1874 of the Social Security Act (“SSA”) states that “[e]xcept as otherwise provided, the Secretary may perform any of his functions under Title 18 directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.” This contracting authority allows for the use of private entities to administer various aspects of the Medicare program.

Claims Processing Contractors

Fiscal Intermediaries and Carriers

Prior to the advent of the Medicare Administrative Contractors (“MACs”), discussed below, Medicare claims were processed by fiscal

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intermediaries ("FLs") and carriers, a division generally based on whether the services or supplies were paid for by Medicare Part A or Medicare Part B. FLs were tasked primarily with the administration of claims for providers of services, which involved making payments for Medicare Part A, and in some cases Part B benefits payable to providers of services on a cost reimbursement basis. FLs also handled claims of dialysis facilities, which are suppliers. Carriers, on the other hand, dealt with suppliers only and made payments for Part B benefits only. The FLs and carriers administered a number of functions, including determining payment amounts, making payments on claims, providing education and assistance to both beneficiaries and providers, communicating with providers and suppliers, and developing local coverage policies.

Local Coverage Determinations ("LCDs"), previously known as Local Medical Review Policies ("LMRPs"), are determinations by a Medicare contractor as to whether a particular item or service is covered by Medicare by that contractor. LCDs are distinct from National Coverage Determinations ("NCDs"), which the Centers for Medicare & Medicaid Services ("CMS") develop to address Medicare coverage for specific items or services that are applicable across all contractors. FLs, carriers, and now MACs are directed to publish an LCD when they have identified an item or service that is not covered in certain circumstances and wish to establish automated review and there is no existing NCD or manual provision supporting automated review. FLs, carriers and MACs also have discretion to develop an LCD when a "validated widespread problem" demonstrates a significant risk of improper payments and when there is a need to further define an NCD. LCDs are developed by considering medical literature, public comments and comments from the provider community.

Medicare contractors must ensure that LCDs do not restrict or conflict with NCDs or coverage provisions in interpretive manuals. LCDs, along with local policy articles, NCDs and proposed NCDs can be accessed through the Medicare Coverage Database.

One notable distinction between an NCD and LCD is the scope of its effect on adjudicators. An NCD is binding on Administrative Law Judges ("ALJs") and the Medicare Appeals Council of the Departmental Appeals Board, whereas ALJs and the Medicare Appeals Council are not bound by LCDs, LMRPs or CMS program guidance such as program memoranda or manual instructions. Despite the fact that they are not bound by this guidance, ALJs and the Medicare Appeals Council are directed to give substantial deference to any applicable policies and explain the reasons why an applicable policy was not followed in a particular case.

FLs and carriers, and now MACs, are also tasked with handling the first level of appeal, known as redetermination, under the Medicare appeals process. Depending on the circumstances surrounding the claim denial, the contractor responsible for the redetermination may be the same contractor that issued the initial determination denying the claim in whole or in part, but where this is the case, different personnel are required to conduct the redetermination review.

Specialty Claims Processing Contractors

In addition to "regular" claims processing contractors, CMS contracted with four specialty contractors, known as Durable Medical Equipment Contractors ("DMERCs"), effective October 1, 1993 to handle the administration of Medicare claims from durable medical equipment, prosthetics, and orthotics ("DMEPOS") suppliers. This change shifted DMEPOS claim processing away from the carrier system in place at the time to four regional carriers. The move to DMERCs was prompted by increasing complaints over the lack of supplier and beneficiary education on Medicare requirements, a lack of basic data by the contractors for use in fraud prevention, a lack of expertise on DMEPOS claim processing, varying claim forms among the carriers and concerns over suppliers "carrier-shopping" for more favorable practices. Prior to the shift to DMERCs, the previous workload was handled by 34 carriers, which resulted in considerable variation in the local coverage policies. In the move to four DMERCs, CMS called for the establishment of standardized medical review policies for the DMEPOS items with the highest allowable charges.

Effective for claims processed on or after October 1, 1998 CMS also awarded a contract for the Statistical and Analysis Durable Medical Equipment Regional Contractors ("SADMERC") to respond to requests for product reviews and post the results of product review coding decisions on its website. The results of product review coding decisions were posted in the Product Classification List, which allowed suppliers to search for codes or fees for a particular product. The SADMERC was also responsible for providing coding assistance to the public regarding DMERC policies and guidelines.

In 1988, as it did for the specialty DMERCs contracted to handle DMEPOS claims, CMS designated four Regional Home Health Intermediaries ("RHIs") to handle claims processing and administration of home health claims.

Medicare Contracting Reform
- MACs, DME MACs and HH+H MACs

Medicare contracting reform resulted in the establishment of new MACs, the division of Medicare services into several categories, and the creation of regional homes for claims processing.
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in the transition of a number of contractors' responsibilities. The goal of Medicare contracting reform was to improve Medicare's administrative services to both beneficiaries and providers and suppliers by using competitive contracting tools and performance incentives. Section 911 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 required CMS to replace FIs and carriers with MACs.23 The MACs were designed to cover multistate regions and process both Medicare Part A and Part B claims, which was intended to reduce the number of contractors with which providers, suppliers and beneficiaries deal. The geographic assignment of a provider or supplier to a particular MAC was based on the state in which the provider or supplier is located, which was a departure from the provider nomination provisions applicable to FIs and carriers.24 CMS currently maintains an interactive map for providers, suppliers and beneficiaries to use to identify the MACs by their geographic jurisdiction.25

CMS began the transition from FIs and carriers to MACs in 2005, utilizing competitively procured contracts. CMS began with 15 regional Part A/B MAC jurisdictions.26 In 2010, CMS announced that it would further consolidate the 15 A/B MAC jurisdictions (1-15) into 10 A/B MAC jurisdictions (E-N) over a several year period. As of March 2014, CMS reported three of the planned contract consolidations, resulting in twelve current A/B MAC contract workloads.27 CMS also imposed a contract limit that restricts the amount of A/B contract responsibility any single entity or set of affiliated entities can obtain. Often one entity will compete and win multiple A/B MAC jurisdictions; for example, Wisconsin Physicians Service holds the A/B MAC contract for Jurisdictions 5 and 8.28 The current contract award limits are 26.0 percent of the national Medicare fee-for-service ("FFS") claims volume for a single prime contractor and 40.0 percent for affiliated A/B MAC contractors.29

Durable Medical Equipment ("DME") MACs were also designated to replace the DMERCs as a component of contracting reform. The DME MACs are divided into four geographic regions, A-D, and process DMEPOS claims under Medicare Part B.30 Notably, the DME MACs process claims based on the Medicare beneficiary's principal state of residence, rather than the location of the supplier.31

Medicare contracting reform also resulted in a shift of the SADMERC's responsibilities to a new contractor: the Pricing, Data Analysis, and Coding contractor known as PDAC. Noridian Healthcare Solutions holds the current PDAC contract and its website explains that it receives, evaluates and processes coding verification applications for DMEPOS; establishes, maintains and updates all coding verification decisions on the product classification list available on the Durable Medical Equipment Coding System (known as DMECS); provides coding guidance for manufacturers and suppliers on proper HCPCS use;32 and conducts DMEPOS data analysis.33

To replace the RHHIs previously designated to handle home health and hospice claims processing, CMS announced in March 2007 four HH+H MACs as part of Medicare contracting reform.34 The HH+H workloads were originally awarded separate jurisdictional MAC contracts, but in March 2007 CMS indicated that it would consolidate the HH+H workloads into four of the A/B MAC contracts. Specifically, A/B MAC jurisdictions 6, 11, 15 and K also include an HH+H workload.

Medicare Administrative Contractors

The MACs are tasked with claims processing and payment, medical review, beneficiary education and assistance, and provider education on billing requirements.35 The MACs' claims processing responsibility is significant; the MACs and other administrative contractors process almost 4.9 million Medicare claims each business day. The MACs also handle provider and supplier enrollment, as well as redeterminations, the first level of the Medicare claims appeals process, as noted above.36 In addition, the MACs are responsible for processing voluntary refunds received from providers.37

MAC Medical Review

One way providers and suppliers may encounter their MAC is in connection with medical review activities. Medical review is defined as "the collection of information and clinical review of medical records...to ensure that payment is only made for services that meet all Medicare coverage, coding, and medical necessity requirements."38 The statutory authority for MAC medical review is based on Sections 1833(e), 1842(a)(2)(B) and 1862(a)(1) of the SSA. The regulatory authority of MACs to conduct medical reviews is outlined in 42 C.F.R. 421.100, 421.200 and 421.400.

The medical review program is aimed at preventing improper payments and reducing payment error by preventing the payment of claims that do not comply with the applicable coverage, coding, payment and billing policies.39 The goal of MAC medical review is to correct behavior and prevent future inappropriate billing, not necessarily identifying potential fraud or abuse.40 In cases where the MAC uncovers repeated infractions or infractions showing
potential fraud, it is directed to refer the case to the Program Safeguard Contractor ("PSC") or Zone Program Integrity Contractor ("ZPIC"), discussed below, for development. 4 The MACs are instructed to develop a problem-focused, outcome-based medical review strategy to target their efforts at error prevention for those services that represent the greatest financial risk to the Medicare program. 42 The MACs seek to identify patterns of potential billing errors concerning coverage and coding policies through data analysis and evaluation of complaints, enrollment information, and/or cost report data. 44 Typically, this involves use of Comprehensive Error Rate Testing ("CERT") error rates and vulnerabilities identified by the Recovery Audit Contractors ("RACs") to focus MAC medical review activities. 44 (CERT contractors and RACs are discussed more fully below.) From here, the MACs analyze their internal claims data to determine what corrective actions can best prevent these vulnerabilities in the future. 45

MAC medical review activities may involve prepayment and postpayment claim review. Prepayment review requires the reviewer to make the claim determination before payment on the claim is made. 46 Medicare contractors do not perform random prepayment review; that is, prepayment reviews are non-random or targeted toward a specific reason that substantiates the cause for review. In recent years, regulatory restrictions on how contractors conduct prepayment reviews were lifted. The Medicare Modernization Act (“MMA”) of 2003 added a statutory subsection that required CMS to establish termination dates for non-random prepayment reviews. CMS issued regulations requiring contractors to terminate non-random prepayment review of a provider or supplier no later than one year following the initiation of the review or when the error rate calculation indicated that the provider reduced its initial error rate by 70 percent or more. 47

The passage of the Patient Protection and Affordable Care Act in March 2010 resulted in a repeal of the statutory basis for the CMS regulation imposing the prepayment review termination criteria. In response, CMS issued a final rule on November 16, 2012 removing the regulation and as a result, contractors are not required to terminate non-random prepayment review within a prescribed time but may "terminate each medical review when the provider has met all Medicare billing requirements as evidenced by an acceptable error rate as determined by the contractor." 48

Postpayment review involves a review of the claim after the claim has been paid. 49 MACs are permitted to conduct postpayment reviews on a claim-by-claim basis or by using statistical sampling to estimate the overpayment for a universe of claims. 50 In order to use a statistical sampling of claims to project an overpayment, the contractor must first determine that there is "a sustained or high level of payment error; or documented educational intervention has failed to correct the payment error." 51 It is important to note that the finding of a "sustained or high level of payment error" is not subject to challenge on appeal. 52

Medical reviews can be provider-specific or service-specific. In cases where data analysis suggests a provider-specific problem, i.e., a potential billing problem that is limited to one or a small number of providers, the MAC is directed to utilize a probe sample of generally 20-40 claims to validate that there is in fact a billing error before significant medical review resources are dedicated to undertaking a larger audit. 53 In contrast, service-specific medical reviews are utilized when the same issue is noted to be widespread and affecting a particular type of service across a jurisdiction. 54 The MACs are directed to notify providers and suppliers of service-specific reviews by posting a review description on their website. 55 One example of a service-specific review is a prepayment review of home visit claims in Illinois instituted by National Government Services ("NGS"). The website notice indicates that NGS will conduct a prepayment review of six home visit CPT codes due to a high rate of billing in comparison to the national Medicare enrollment for the state. 56

MAC claim review activities can involve non-complex or complex reviews. Non-complex reviews do not involve a review of medical records submitted by the provider or supplier, whereas complex reviews do incorporate a clinical review of the medical documentation. 57 In complex claim reviews, the MAC requests the medical documentation supporting the claim through the use of additional documentation requests ("ADRs"). The Medicare Program Integrity Manual sets forth timeframes for providers and suppliers to respond to ADRs in both prepayment and postpayment claim review situations. 58 MACs are directed to apply coverage provisions and policies set forth in the SSA, regulations, CMS Guidelines, NCDs, Manual guidance, CMS coding policies, Technical Direction Letters, the relevant MAC’s LCDs and articles, and AHA Coding Clinics. 59 In practice, MACs focus much more on sub-regulatory guidance that they do the statute and regulations. The MACs are also directed to apply coding guidelines including CPT, ICD-9, HCPCS, and CMS coding policies. 60 In addition, the MACs have discretion to develop detailed written review guidelines for their staff. 61

In evaluating claims under review, the MACs are also tasked with determining if the provider or supplier qualifies for waiver of liability under Section 1870 of the SSA or whether the provider or supplier should receive limitation of liability protection under continued on page 6
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Section 1879. At the conclusion of the claim review, the MAC sends a review results letter, separately or accompanied by a demand letter, outlining the specific issues involved in the overpayment, and a specific explanation of why any services were determined to be non-covered, as well as any recommended corrective action.

In addition to conducting their own claim reviews, the MACs are responsible for issuing demand letters for overpayments identified through RAC and ZPIC audits. The MACs are also responsible for initiating recoupment of Medicare overpayments where applicable.

MAC Improper Payment Outreach and Education Program

Congress recently mandated that the Secretary implement an improper payment outreach and education program through the MACs. Each MAC is required to furnish providers and suppliers with certain information that the Secretary determines to be appropriate, which may include information relating to the providers and suppliers with the highest rate of improper payments and with the greatest total dollar amounts of improper payments, as well as items and services furnished in the region that have the highest rates of improper payments and that are responsible for the greatest total dollar amount of improper payments. MACs are required to give priority to activities under the improper payment outreach and education program that will reduce improper payments that are one or more of the following: (1) items and services that have the highest rate of improper payment; (2) items and services that have the greatest total dollar amount of improper payments; (3) due to clear misapplication or misinterpretation of Medicare policies; (3) clearly due to common and inadvertent clerical or administrative errors; and (5) due to other types of errors that the Secretary determines could be prevented through activities under the program.

In order to assist MACs in carrying out the improper payment outreach and education programs, the Secretary is required to provide each MAC with a complete list of the types of improper payments identified by RACs with respect to providers and services and suppliers located in the MAC's jurisdiction.

The Middle Ground: Contractors in Between Claims Processing and Program Integrity

There are several contractors that fall in between claims processing and program integrity contractors: the CERT contractor, the National Supplier Clearinghouse ("NSC"), Quality Improvement Organizations ("QIOs") and the RACs. These contractors have responsibilities related to claims and program integrity, but do not actually process claims and are not strictly defined as program integrity contractors.

Comprehensive Error Rate Testing

The CERT program is used to calculate the Medicare FFS improper payment rate. Historically, the Department of Health and Human Services' Office of the Inspector General ("OIG") was responsible for estimating the improper payment rate for Medicare FFS from 1996-2002. Due to the small sample size used by the OIG, the improper payment rate calculation could not be broken down further by contractor, contractor type, service type or provider type. In 2001, the OIG and CMS decided to shift responsibility for producing the Medicare FFS improper payment rates to CMS. Shortly thereafter, the CERT program was created in 2003. The CERT program was developed to comply with the requirements of the Improper Payments Information Act ("IPIA") of 2002, as amended by the Improper Payments Elimination and Recovery Improvement Act ("IPERIA") of 2012, which requires federal agencies to estimate the amount of improper payments in the programs they administer. HHS publishes the improper payment rate in the Agency Financial Report each November.

Each year, the CERT program evaluates a statistically valid random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. The CERT improper payment rate is not a measurement of the rate of incidents of fraud, but of payments that did not meet the Medicare requirements. The CERT measurement involves a stratified random sample of approximately 40,000 claims submitted to MACs and DME MACs, which enables the contractors to calculate national improper payment rates, as well as contractor-specific and service-specific improper payment rates. The CERT program uses two contractors: the CERT Documentation Contractor ("DC"), which requests and receives the medical record documentation from the provider or supplier, and the CERT Review Contractor ("RC"), which reviews the selected claim together with the associated medical record documentation. Claims reviewed as part of the CERT improper payment calculation are subject to postpayment denials, payment adjustments or other administrative or legal actions. Claims reviewed by the CERT contractors may be appealed through the Medicare claims appeals process.

National Supplier Clearinghouse

The NSC contractor is responsible for enrolling and disenrolling
DMEPOS suppliers. The NSC processes supplier enrollment applications (the CMS-855S) and verifies the information provided. The NSC may then conduct a site visit to ensure the supplier’s compliance with the DMEPOS supplier standards contained at 42 C.F.R. 424.57. DMEPOS suppliers are also required to notify the NSC of changes to their enrollment information. Palmetto GBA holds the current NSC contract.

Quality Improvement Organizations

QIOs are tasked with improving the quality of healthcare for Medicare beneficiaries. The mission of the QIO program is to “improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.” CMS defines the core functions of the QIO program as improving quality of care for beneficiaries; protecting the integrity of the Medicare Trust Funds by ensuring Medicare pays for only goods and services that are reasonable and necessary and provided in the most appropriate setting; and protecting beneficiaries by addressing complaints (including individual beneficiary complaints, provider-based notice appeals, and Emergency Medical Treatment and Labor Act (“EMTALA”) violations). QIOs also perform DRG validation on hospital PPS claims. QIOs are comprised primarily of physicians, nurses, other clinicians, health quality experts and consumers.

The QIO program, formerly the Utilization and Quality Control Peer Review Program, was originally established in 1982 by Sections 142 and 143 of the Tax Equity and Fiscal Responsibility Act. The individual organizations were initially known as “Peer Review Standards Organizations” (and then “Peer Review Organizations”) before the regulatory references to these organizations were changed to QIOs. Section 261 of the Trade Adjustment Assistance Extension Act of 2011 authorized changes to the original QIO Program in an effort to modernize the program and add flexibility to the program’s structure. As a result, CMS redesigned the QIO program to incorporate several key changes. First, QIO contracts may now be awarded on a regional basis. Historically, states contracted with a QIO to carry out case review and quality improvement functions on a state-by-state basis. Second, the statutory and regulatory revisions now permit QIOs to perform one or more of the QIO functions rather than requiring one QIO contracted entity to perform all of the functions. For example, one QIO for a particular geographic jurisdiction may be tasked with case review responsibility, whereas another QIO entity for the same jurisdiction may take responsibility for implementing quality improvement initiatives. Recent regulatory changes also expanded the scope of entities eligible to be awarded a QIO contract by focusing on the functions that the organization would perform under the QIO contract rather than on the structure of the organization. Finally, the contract term for QIOs was also recently increased from three to five year terms.

Recovery Audit Contractors

RACs, sometimes also known as recovery auditors, are probably the most talked about contractor of the last decade. Whereas the RACs audit claims and perform medical reviews as a component of the Medicare Integrity Program, their primary focus is identifying improper payments, not detecting fraud, waste and abuse. As discussed below, the Patient Protection and Affordable Care Act extended the scope of their audit authority to include Medicare Parts C and D as well as Medicaid.

Medicare RACs

The use of RACs in the Medicare FFS program began as a demonstration program authorized by Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The demonstration program ran from March 2005 through March 2008 in six states in an effort to evaluate the effectiveness of the RACs at identifying improper payments. The demonstration project established the RACs as successful, and the RAC program was made permanent and expanded nationwide by Section 302 of the Tax Relief and Health Care Act of 2006.

The goal of the RAC program is to identify and correct improper payments, both overpayments and underpayments. RACs are not claims processing contractors like MACs, although they follow primarily the same regulations and policies as the MACs with regard to their medical review activities. The RACs are also required to follow the requirements set forth in the RAC Statement of Work.

There are four RACs, each responsible for a geographical area that covers roughly one-quarter of the country. Given their larger geographical regions, the RACs are able to conduct more widespread reviews. The Statement of Work authorizes the RACs to audit claims on a post-payment basis. RACs, like MACs, utilize automated (non-complex) and complex reviews, and also engage in a third type of review: semi-automated review. Semi-automated reviews involve identification of a billing aberrancy through automated analysis of claims data that suggests a likelihood of an improper payment. From there, the provider is sent a notification letter explaining the potential billing error and requesting supporting documentation.

In September 2012, CMS implemented a three-year prepayment review demonstration program for the RACs. The prepayment demonstration was limited to 11 states with either high levels of improper payments or high claim volumes for hospital inpatient short-stay claims.
In the demonstration states, certain MS-DRGs were flagged for review before the claims were paid. Therapy claims were also added to the RAC prepayment demonstration for the 11 states in April 2013. In these cases, prepayment review was required when therapy services for a beneficiary reached a threshold in a calendar year. RAC prepayment review of inpatient short-stay claims was ceased effective for discharges occurring on or after October 1, 2013 following the so-called 2-Midnight billing policy for short-stay hospital admissions set forth in the FY 2014 Inpatient Prospective Payment System ("IPPS") final rule. Similarly, the prepayment review of therapy claims was paused in preparation for procurement of new recovery audit contracts on February 28, 2014. Claims submitted from this time period that exceed the annual threshold will not be subject to review on a prepayment basis.

One of the key distinctions between the RACs and other contractors is that they are paid on a contingency fee basis. The contingency fees, which initially ranged from 9.0-12.5 percent for Medicare FFS claims, are a percentage of the improper payments recovered from (or reimbursed to) audited providers. RACs are required to return the contingency fee payment for claim determinations overturned at any level of the appeal.

Although RACs potentially may review all claim types, CMS expects that they will focus on identifying improper payments that have the greatest impact on the Medicare Trust Fund. Their contingency fee arrangement further incentivizes the RACs to target claims with the potential for high-dollar value overpayments. Before a RAC undertakes a new issue for review, it must first "validate" the issue with CMS. CMS or its RAC Validation Contractor must review and approve the issue before the RAC is permitted to issue ADR letters to providers and suppliers requesting documentation. Once an issue is approved, the RAC is required to post a description of the issue on its website. In conducting their claim review activities, the RACs are limited to a three-year look back period from the date the claim was paid.

The RAC Statement of Work encourages the use of statistical extrapolation for some claim types, particularly those claims with a low dollar claim value, requiring complex review and a history of having a high error rate. The Statement of Work directs that the use of extrapolation must be approved for each issue prior to beginning.

Congress has recently required the Secretary to retain a portion (not to exceed 15 percent) of the RACs' recoveries, which is to be used to reduce the Medicare claims error rate. The retention of payments cannot have the effect of reducing the RAC's payments that are otherwise due.

Medicare Parts C & D RACs

Section 6411(b) of the Patient Protection and Affordable Care Act amended Section 1893(h) of the SSA to provide the general authority for CMS to contract with RACs to identify improper payments in Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Benefit). Applying the RAC program concept to Medicare Part C presents challenges due to the prospective nature of Medicare Advantage payments. As a result, there is limited information available regarding the Part C RAC program to date. The Part D RAC employs a similar model to that used in the Medicare FFS RAC program. The Part D RAC reviews previously paid individual Medicare claims to sponsoring organizations or pharmacies to determine if an overpayment or underpayment was made, and reports information to CMS to prevent future improper payments. If any potential fraud findings are identified during the RAC audit process, they are referred to the Medicare Drug Integrity Contractor, explained below. ACLR Strategic Business Solutions is the current Part D RAC. Similar to the new issue validation process used in the Medicare FFS RAC program, the Part D RAC program utilizes a data validation contractor. In addition to reviewing suggested new audit issues, the Part D Data Validation Contractor analyzes random samples of prescription drug events that have been identified by the RAC to contain improper payments and either concurs or disagrees with the RAC's findings. Livanta, LLC is the current Part D RAC Data Validation Contractor.

Medicare Program Integrity Contractors

Previously, FIs and carriers performed Medicare benefit integrity functions. The Health Insurance Portability and Accountability Act ("HIPAA") of 1996 established the Medicare Integrity Program in an effort to strengthen CMS' ability to detect and deter potential fraud, waste, and abuse in the Medicare program. CMS created new entities, known as PSCs, to perform program integrity functions. Subsequently, PSCs were transitioned to new entities known as ZPICs to carry out program integrity activities in seven regional program integrity zones. The ZPICs handle program integrity functions for Medicare Part A, Part B, DMEPOS, Home Health and Hospice and Medicare-Medicaid (Medi-Medi) data matching. A separate contractor,
the Medicare Drug Integrity Contractor ("MEDIC") handles program integrity efforts for Medicare Part C and D. Both ZPICs and the MEDIC work under the direction of the Center for Program Integrity ("CPI") in CMS. CMS' arsenal of program integrity contractors currently includes ZPICs, RACs, Medicaid Integrity Contractors ("MICs"), the Medicare Secondary Payment Contractor ("MSRPC"), Unified Program Integrity Contractors ("UPICs") and the MEDIC.

Program Safeguard Contractors/ Zone Program Integrity Contractors

The primary task of PSCs and ZPICs (hereinafter collectively referred to as ZPICs) is to identify and develop cases of suspected fraud as well as to take immediate action to ensure that the Medicare Trust Fund monies are not inappropriately paid out and that mistaken payments are recouped. The focus of ZPICs is to respond quickly to suspected fraud or abuse and employ administrative actions.

ZPICs are organized with a Medical Review ("MR") Unit and a Benefit Integrity ("BI") Unit. As outlined in Chapter 4 of the Medicare Program Integrity Manual, the ZPIC BI Unit has a number of responsibilities, including (1) preventing fraud or abuse by identifying program vulnerabilities; (2) proactively identifying incidents of potential fraud or abuse that exist within its service area and taking appropriate action on each case; (3) investigating (determining the factual basis of) allegations of fraud or abuse made by beneficiaries, providers, suppliers, CMS, OIG and other sources; (4) exploring all available sources of leads of suspected fraud or abuse in its jurisdiction, including those emanating from the Medicaid Fraud Control Unit ("MFCU") and its corporate anti-fraud unit; (5) initiating appropriate administrative actions to deny or suspend payments that should not be made to providers where there is reliable evidence of fraud; (6) referring cases to the OIG's Office of Inspections ("OI") for consideration of civil and criminal prosecution and/or application of administrative sanctions; and (7) referring any necessary provider and beneficiary outreach to the Provider Outreach and Education staff at the Affiliated Contractor ("AC") or MAC. The ZPICs are also responsible for processing complaints alleging DMFPOS fraud within their region/zone. To carry out these responsibilities, ZPICs utilize data analysis and referrals from MACs or other medical review contractors as well as complaints to identify leads. ZPICs are directed to refer cases of potential fraud to the OIG/OI.

Once the ZPIC or the referring contractor identifies patterns of claim submissions or payments that indicate potential problems, the ZPIC may utilize prepayment or postpayment review to verify the potential errors. Whereas medical review activities for MR purposes focuses on evaluating the correct coverage or coding determination, medical review for BI purposes may focus on identifying possible falsification, evidence of a trend to use higher codes, obvious or nearly identical documentation, or evidence of alteration to the records, among others. In cases where an overpayment is identified, the ZPIC refers the overpayment to the appropriate MAC, which is required to issue a demand letter and recoup the overpayment. Like the MACs and Medicare RACs, ZPICs are authorized to use statistical sampling to calculate and project the amount of the overpayment across a larger universe of claims.

ZPICs also have the ability to suspend Medicare payments to a provider. When the ZPIC has received approval from CMS to suspend payments to a provider, the ZPIC is directed to coordinate with the appropriate MAC to institute a payment suspension.

Medicare Drug Integrity Contractor

The MEDIC is tasked with detecting and preventing fraud, waste and abuse in the Medicare Part C and Part D programs. The MEDIC program has evolved considerably over the last seven years. In 2007, CMS contracted with three regional MEDICs to handle potential fraud and abuse in Part D. In 2009, the MEDIC program was transitioned from three regional contractors to two, which were also given oversight responsibility for Medicare Part C. In 2010, the program was restructured into two national (rather than regional) MEDICs, one tasked with National Benefit Integrity ("NBI") and the other with Compliance & Enforcement ("C&E"). The NBI MEDIC has responsibility for preventing and detecting fraud, waste and abuse in Parts C & D nationwide and the C&E MEDIC has nationwide responsibility for compliance and enforcement activities. CMS subsequently continued the NBI MEDIC activities, and the C&E MEDIC was tasked with performing special and ad hoc studies and ongoing technical support for CMS and the NBI MEDIC.

Focusing on the NBI MEDIC, the MEDIC Statement of Work outlines the following responsibilities: (1) review the fraud and abuse components of Part C and Part D sponsoring organizations; (2) process Part D and Medicare Advantage workloads to identify and deter fraud, waste and abuse; (3) assist CMS in developing a "watch" list of entities requiring future monitoring; (4) evaluate inappropriate activities through claim and drug utilization patterns and detection of outliers, such as services not rendered, services not medically necessary, off-label drug use, inappropriate coverage of drugs, and inappropriate changes in formulations; (5) conduct reviews and audits; (6) conduct complaint investigations; (7) conduct preliminary investigations into fraudulent enrollments, continued on page 10
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eligibility determinations and benefit distribution; (8) investigate aberrant behavior and develop and refer cases to appropriate law enforcement agencies or recommend administrative action; (9) identify vulnerabilities in the Part C and Part D programs; and (10) provide support to law enforcement agencies in connection with investigations. 143 The MEDIC is directed to use proactive data analysis as well as investigate external referrals of potential fraud. If the MEDIC substantiates a fraud allegation, it then refers the allegation to law enforcement. Where a case has been referred to the OIG/OI, the OIG/OI has 90 calendar days to accept the referral, refer it to the Department of Justice or reject the case. 146 If a determination is not made by the OIG/OI, the case is then referred to the Federal Bureau of Investigation (“FBI”) or another investigative agency with interest in the case. 147 In cases where the OIG, FBI or another investigative agency does not accept the case or render a decision, the NBI MEDIC remains responsible for taking any actions to protect the Medicare Trust Funds. 148

A 2013 OIG Report found that Medicare Part C investigations and case referrals accounted for a small percentage of the MEDIC’s BI activities due to the lack of a centralized Part C data repository, an inability to share information with other program integrity contractors and limited ability to recover payments from plan sponsors. 149 CMS responded that it expected to provide the MEDIC access to a central repository of data and offer guidance on appropriate situations in which to share information with ZPICs and state agencies in the future. 150 Health Integrity holds the current NBI MEDIC contract.

Benefit Coordination & Recovery Center

The Medicare Secondary Payer (“MSP”) program is designed to ensure that Medicare is aware of situations in which it should not be the primary payer of claims. 151 In situations where a beneficiary has Medicare and some other health insurance, Coordination of Benefits (“COB”) rules decide which entity pays first. 152 Sometimes, after payment on a claim has already been made, CMS may receive new information indicating that Medicare made a primary payment by mistake because it was not the primary payer. Previously, CMS utilized the Medicare Secondary Payer Recovery Contractor (“MSPRC”) to make efforts to recover these payments. On February 1, 2014, CMS consolidated the MSPRC and the Coordination of Benefits Contractor (“COBC”) into the new Benefits Coordination & Recovery Center (“BCRC”). 153 Group Health Incorporated holds the current BCRC contract. 154 All MSP claims investigations are initiated from and researched by the BCRC. 155 The BCRC handles coordination of benefits actions for group health plans (“GHPs”) and non-group health plans (“NGHPs”), as well as recovery activities for NGHPs. 156 If it is determined that a GHP is the proper primary payer on a claim, the Commercial Repayment Center (“CRC”) will seek recovery from the Employer and GHP. 157 If it is determined that an NGHP is the proper primary payer, as may be the case with liability, No-Fault, and Workers’ Compensation claims, the BCRC is responsible for the recovery of mistaken payment. 158

Medicaid Contractors

Medicaid RACs

Section 6411(a) of the Patient Protection and Affordable Care Act expanded the RAC program to Medicaid. Each state Medicaid program was required to establish a RAC program by contracting with one or more entities to serve as the Medicaid RAC or seek an exception. Like the Medicare RACs, the Medicaid RACs are tasked with identifying underpayments and overpayments and recouping overpayments for the states. The Medicaid RACs are paid on a contingency fee basis, with the specific contingency fee rate set by the state up to a maximum specified by CMS. 159 If the state exceeds the maximum contingency fee without obtaining a waiver from CMS, the amount exceeding the maximum rate is not eligible to be paid with federal funds. 160

While the regulations allow the states flexibility to craft Medicaid RAC programs that fit their specific needs, they also impose several requirements. The states are required to set limits on the number and frequency of medical records reviewed by the Medicaid RACs. 161 Likewise, the Medicaid RAC must hire a full-time contractor medical director and certified coders, unless it is determined that coders are not necessary for the review of Medicaid claims. 162 The Medicaid RAC is also required to provide a toll-free customer service number and accept provider submissions of electronic records on CD/DVD or through facsimile if requested. 163 The Medicaid RACs are limited to a look-back period of three years from the date of the claim unless they receive approval from the state. 164

States were required to have a signed contract in place with a Medicaid RAC entity by January 1, 2012 or submit a state plan amendment to CMS by that date. 165 At the time of this writing, all states have filed and received approval of a state plan amendment, with some states seeking exemptions from the RAC audit scope in order to integrate current state Medicaid audit efforts with the requirements of the Medicaid RAC program. 166 Many states have contracted with one or more RACs or converted existing contracts with contractors to include RAC
The nature of current Medicaid RAC audit activities varies by state and is best assessed by reviewing the individual state’s Medicaid RAC contractor information. Medicaid Integrity Program

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (“MIP”) under Section 1936 of the SSA. The program is a comprehensive federal strategy to prevent and reduce provider fraud, waste and abuse in the Medicaid program, the costs of which are shared by the state and federal governments. Previously, the states were primarily responsible for identifying and stopping Medicaid fraud.

At the inception of the MIP, CMS hired three types of contractors, known as Medicaid Integrity Contractors (“MICs”), to perform review, audit and education functions. Review MICs were tasked with analyzing Medicaid claims data to identify whether fraud, waste or abuse had or was likely to occur. The Review MICs then referred the leads they identified to the Audit MICs to perform postpayment claim review to ensure proper payments were made and identify any overpayments. CMS also contracted with Education MICs who were responsible for educating providers, beneficiaries and managed care entities on program integrity and quality of care issues.

An OIG Report from March 2012 identified several challenges that limited the effectiveness of the MICs. First, Review MICs were having difficulties identifying audit targets due to missing or incomplete data in the Medicaid Statistical Information System (“MSIS”). Due to missing provider identification information, adjustments that corrected claims and service and beneficiary descriptions, the Review MICs were incorrectly identifying potential overpayment targets. Once potential targets were identified, CMS would assign the audit targets to the Audit MICs to conduct postpayment claim review. If the Audit MIC identified an overpayment it would submit a draft audit report to CMS, which reviewed the report for quality assurance and submitted it to the state and provider for comment. Upon receiving the comments from the state and provider, the Audit MIC made any necessary revisions to the report and submitted the final report to CMS. The 2012 OIG report analyzed the audit activities of the Audit MICs for a six-month period between January 1 and June 30, 2010 and concluded that 81 percent of the MIC audits did not or were not likely to identify Medicaid overpayments. The ineffectiveness of the Audit MICs was attributed to the inability of the Review MICs and CMS to identify audit targets. In response to the MICs’ limited effectiveness, CMS made several changes to the program. In February 2011, CMS stopped assigning audit targets to the Audit MICs based solely on data from the MSIS. In addition, CMS did not renew Review MIC contracts but rather allowed them to expire.

Current MIP activities involve several different contractors. The Audit MICs, in collaboration with the states, conduct postpayment review of Medicaid providers. State collaboration has been determined to improve the selection of audit targets and provides the Audit MICs with familiarity regarding state-specific Medicaid policies. When an Audit MIC identifies an overpayment, the state is ultimately responsible for collecting the overpayment from the provider. CMS collects the federal share of the overpayment from the state, regardless of whether the state is able to recover from the provider. CMS also currently utilizes ZPICs to conduct Medi-Medi data matching activities, which involves analyzing both Medicare and Medicaid claims data to identify duplicate or improper claims billed to both programs.

Payment Error Rate Measurement Program

Similar to the Medicare CERT program, the Payment Error Rate Measurement ("PERM") program measures improper payments in Medicaid and the Children’s Health Insurance Program ("CHIP") and calculates error rates for each program. Error rates are based on reviews of the FFS, managed care, and eligibility components in the programs for a fiscal year period. The error rate calculation is a measurement of the payments that did not meet statutory, regulatory or administrative requirements, but not necessarily fraudulent payments. The PERM program is used by CMS to comply with the requirements of IPIA (as amended by IPERA).

The 2013 Improper Payments Report describes the process used by the PERM program to measure improper payments. PERM uses a 17-state three-year rotation cycle to measure improper payments. To calculate the error rates, CMS measures a third of the states each fiscal year. The reported Medicaid and CHIP program error rates for a given fiscal year include findings from the most recent three measurements to reflect findings from all 50 states and the District of Columbia. The PERM program uses two contractors, the PERM Statistical Contractor (“SC”) and the PERM Review Contractor (“RC”) to carry out its error rate testing. The current PERM SC is the Lewin Group and the current PERM RC is A+ Government Solutions.

The Future of CMS Contracting

Supplemental Medical Review Contractor

The Supplemental Medical Review Contractor ("SMRC") is contracted by CMS to perform a variety of tasks focused on lowering improper payment rates and increasing medical review efficiencies across the Medicare and Medicaid programs. The SMRC achieves these goals by identifying provider non-compliance with coverage, coding, billing and payment...
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policies; performing medical review and statistical sampling activities at the direction of CMS; making recommendations to ZPICs; and conducting provider outreach and education where appropriate.291 CMS contracted with StrategicHealthSolutions, LLC as the SMRC on September 27, 2012.292

One of the SMRC's primary tasks is conducting nationwide medical review activities assigned by CMS.193 Specifically, CMS selects services and provider specialties to be reviewed by the SMRC using (but not limited to), data analysis, as well as issues identified by CERT reviews, professional organizations, other federal agencies and comparative billing reports.194 The SMRC is then assigned each project through Technical Direction Letters ("TDL") issued by CMS.195 The SMRC's medical review activities are subject to the guidelines set forth in the Medicare Program Integrity Manual. Upon completion of a medical review, the SMRC notifies CMS of the identified improper payments and CMS directs the appropriate MAC to initiate claim adjustments or overpayment recoupment.196 Providers can appeal a SMRC determination through the Medicare appeals process once an overpayment demand letter is received from the MAC.197

The SMRC is required to maintain a website that lists the types of issues under review, together with a link to relevant reports on the issue. Providers are notified of SMRC audits through ADRs requesting documentation.198 StrategicHealthSolutions currently maintains a website listing both current and completed SMRC review projects. Although the description of the SMRC program indicates that the contractor may focus on both Medicare and Medicaid claims, the current and completed review projects involve only Medicare.199

Unified Program Integrity Contractors

To coordinate federal program integrity work, CMS has announced it is developing a new contractor, the Unified Program Integrity Contractor (UPIC), to consolidate Medicare and Medicaid data analysis and audit and investigation work.200 Pursuant to a Request for Information ("RFI") published in July 2013, CMS's CPI announced the concept of "a unified program integrity strategy [that] involves contractors performing work across the Medicare and Medicaid Program integrity continuum."201 The RFI, which is a market research tool used to obtain information, explains that "the program incorporates data matching, coordination, and information sharing to identify fraudulent or wasteful billing behavior that goes undetected when the programs are reviewed in isolation." CMS states that it plans to establish several (between 5-15) regional UPICs, each of which would support Medicare and Medicaid program integrity requirements in designated states.202 UPICs would integrate audit and investigations across Medicare and Medicaid including functions currently performed by ZPICs (i.e., their Medicare-Medicaid Data Match responsibility), PSCs and Medicaid Integrity Contractors (MICs). CMS expects to implement the UPIC program beginning in FY 2015.203

Conclusion

The number and focus of CMS contractors continue to evolve as new programs are established and existing programs are reevaluated. Although the landscape of contractors is vast, it is important for healthcare providers and their counsel to understand the underlying goals of the various CMS programs in order to better understand the focus and actions of the contractor they are dealing with.

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Endnotes

1 42 U.S.C. § 1395kk.
2 The Medicare statute recognizes two mutually exclusive categories of entities or individuals who deliver healthcare services. A "provider of services" includes "a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, and hospice program." 42 U.S.C. § 1395x(a). A "supplier" is "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services." 42 U.S.C. § 1395x(d). "Providers of service" and "supplier" are also defined at 42 C.F.R. § 400.202.
5 42 U.S.C. § 1395f. LMRPs were converted to LCDs as a result of the Beneficiaries Improvement and Protection Act of 2000. LCDs contain only "reasonable and necessary conditions of coverage" as allowed under SSA § 1862(a)(1)(A), whereas LMRPs may have also contained other information such as coding and payment guidelines. Coding and payment guidelines are now published in articles that may accompany a LCD. See www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html.
6 42 C.F.R. § 405.1060.
7 Medicare Program Integrity Manual ("MPIM"). Pub. 100-08, Chapter 13, Section 13.4.
8 MPIM, Pub. 100-08, Chapter 13, Section 13.4. See also https://www.cms.gov/Research-Statistics-Data-and-Systems/monitoring-programs/Medicare-FFS-Compliance-Programs/Medicare-Review.
9 MPIM, 100-08, Chapter 13, Section 13.1.3.
10 MPIM, 100-08, Chapter 13, Section 13.5.
12 42 C.F.R. § 405.1060; 42 C.F.R. § 405.1062. There are five levels of appeal within the Medicare appeals process. The AJ stage is the third level of appeal, followed by a fourth-level appeal to the Medicare Appeals Council.
13 42 C.F.R. § 405.1062.
14 42 U.S.C. § 1395f(a)(3) (SSA 1869a(a)(3)).
15 42 C.F.R. § 405.948. (See also: 42 U.S.C. § 1395f(a)(3)).
24 42 C.F.R. § 421.404. See also www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Provider-Agreement-and-MACs.html.
32 As explained by CMS, the HCPCS or Healthcare Common Procedure Coding System is the standard code set for items and services furnished in outpatient settings, such as physicians' offices, hospital outpatient departments, and patients' homes. The HCPCS code set is divided into two principal subsystems, referred to as Level I and Level II. Level I consists of the Current Procedural Terminology ("CPT"), an alpha-numeric coding system maintained by the American Medical Association to identify medical services and procedures furnished by physicians and other healthcare professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the Level II HCPCS codes were established for use in submitting claims for these items. Level II codes are maintained and distributed by CMS, taking into consideration input from all insurers including Medicare, Medicaid, and private payor organizations. See CMS Innovators Guide 2010 at 22-23, available at www.cms.gov/Medicare/Coverage/CounselorTechInnovation/downloads/InnovatorsGuide_10_10.pdf.
37 MPIM, Pub. 100-08, Chapter 4, Section 4.16 Medicare Financial Management Manual ("MPMM"), Pub. 100-06, Chapter 4, Section 10.14.
38 www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medicare-Review.
39 MPIM, Pub. 100-08, Chapter 1, Section 1.3.8.
40 MPIM, Pub. 100-08, Chapter 3, Section 3.1.
41 MPIM, Pub. 100-08, Chapter 1, Sections 1.3.6, 1.3.10.
42 MPIM, Pub. 100-08, Chapter 3, Section 3.2.1.
43 MPIM, Pub. 100-08, Chapter 1, Section 1.3.8.
44 MPIM, Pub. 100-08, Chapter 1, Section 1.3.1(B).
45 MPIM, Pub. 100-08, Chapter 1, Section 1.3.1(B).
46 MPIM, Pub. 100-08, Chapter 3, Section 3.2.
49 MPIM, Pub. 100-08, Chapter 3, Section 3.2.
50 42 U.S.C. § 1395dd(d)(3): MPIM, Pub. 100-08, Chapter 3, Section 3.5.2. Statistical sampling is sometimes used as a means to calculate an overpayment through extrapolating the results of the sampling.
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1870 waiver of liability provisions, an overpayment made to a provider or supplier will not be recouped if the provider or supplier was without fault in causing the overpayment and recouping the overpayment would defeat the purpose of Title xviii or would be against equity or good conscience. Under Section 1879 limitation of liability, a provider or supplier may receive payment for a claim that is otherwise unallowable for certain reasons (chiefly, lack of medical necessity) if the provider did not know or could not have reasonably been expected to know that the claim was not allowable.

63 MPIM, Pub. 100-08, Chapter 3, Section 3.64.

64 Section 505(a) of the Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10.


66 Section 505(a)(2) of the Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10. Other changes made by this section include providing for a 10-year rather than a 5-year MAC contract, and requiring the Secretary to make available to the public the performance of each MAC.


69 www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Background.html.

70 www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/FY2003LongReport.pdf, Appendix D. Following the move from GIG to CMS, CMS tasked the CERT Program with determining the percentage of Medicare payments made where the claim did not meet the Medicare coverage, coding and billing rules.

71 www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Background.html.

72 www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Background.html.

73 MPIM, Pub. 100-08, Chapter 12, Section 12.3. See also www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERTReports.html.

74 MPIM, Pub. 100-08, Chapter 12, Section 12.3.

75 www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Background.html.


77 MPIM, Pub. 100-08, Chapter 12, Section 12.3.4. See also www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/Medicare-Claim-Review-Programs.pdf.

78 MPIM, Pub. 100-08, Chapter 12, Section 12.3.5. See also www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/Medicare-Claim-Review-Programs.pdf.

79 42 C.F.R. § 454.37.


82 SSA 1862(g); 42 U.S.C. § 1395y.

83 www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorganizati... See also Quality Improvement Organization Manual, Pub. 100-10, Chapter 1, Section 1005. BMTALA is contained at Section 1867 of the SSA, 42 U.S.C. § 1395dd. Under BMTALA, an individual (Medicare beneficiary or otherwise) comes to a hospital emergency department, and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition exists. If the hospital determines that an emergency condition exists, the hospital must attempt to stabilize the individual's condition or effect an appropriate transfer.

84 Quality Improvement Organization Manual, Pub. 100-10, Chapter 4, Section 4130. Short-term acute care hospitals are paid under the Inpatient Prospective Payment System ("IPPS") under Section 1886(d) of the SSA, 42 U.S.C. § 1395ww. Under the IPPS, an inpatient's diagnosis is assigned to a Diagnosis Related Group ("DRG"), for which the hospital receives a prospectively determined amount regardless of the resources used (as multiplied by a wage index and subject to certain add-ons, where applicable, and outlier payments for especially high costs incurred in treating the patient).


94 Recovery Auditing in Medicare for Fiscal Year 2013, FY 2013 Report to Congress (p. 2).


96 42 U.S.C. § 1395dd(h).

97 MPIM, Pub. 100-08, Chapter 3, Section 3.3.2.

98 Recovery Auditing in Medicare for Fiscal Year 2013, FY 2013 Report to Congress (p. 2).

99 RAC Final Statement of Work, September 1, 2011.

100 Id.

101 Id.

102 Id.


105 The Medical Severity Diagnosis-Related Group ("MS-DRG") classification system is a refinement over the DRGs system of classification. There are three levels of severity included in the MS-DRG classification system, which are: major complication/comorbidity; complication/comorbidity; and noncomplication/comorbidity. These levels are calculated based on clinical factors—primarily the patient's secondary diagnosis codes (such as pneumonia or sepsis) in addition to the primary diagnosis (hip fracture). Earlier iterations of DRG systems focused more on the institutional side, with the computational logic guided more by resources used rather than the diseases and patients treated.


107 CMS-1599-0, 78 Fed. Reg. 50195-51040 (August 19, 2013). Congress has imposed a moratorium on CMS from allowing the RACs or other contractors to conduct inpatient hospital patient status reviews. The latest extension of the moratorium applies to discharges occurring on or after October 1, 2013 through September 30, 2015. Section 521 of the
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177 42 C.F.R. § 433.316.
179 The Children’s Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs under Title XXI of the SSA. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. The CHIP program was recently extended through September 30, 2017 by Section 301 of the Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10.
177 MSIS is a nationwide Medicaid eligibility and claims data source containing a subset of data elements from state data systems that states report quarterly to CMS. MSIS data are a specified subset of fields extracted from each state’s Medicaid Management Information System (“MMIS”). MMIS enables states to process claims and monitor use of services. MSIS includes four Medicaid claims files: (1) inpatient care; (2) long-term care; (3) prescription drugs; and (4) all other claims, along with files of eligible Medicaid enrollees. http://oig.hhs.gov/oeti/reports/oeti-05-10-00210.pdf, p.3.

190 MPIM, Pub. 100-08, Chapter 1, Section 1.3.1.
191 MPIM, Pub. 100-08, Chapter 1, Section 1.3.8.
194 MPIM, Pub. 100-08, Chapter 1, Section 1.3.1.
198 MPIM, Pub. 100-08, Chapter 3, Section 3.2.2.

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