RAC MONITOR

The Landscape of Medicare and Medicaid Contractors

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With the attention of recent years focused on Recovery Audit Contractors (RACs), providers may be unfamiliar with the Centers for Medicare and Medicaid Services' (CMS) other audit contractors. CMS recently released a MLN Matters article in an effort to increase provider awareness of the current contracting environment and the various entities that may request medical records or other documentation. It is important for providers to recognize the various CMS contractors and the different roles they play. Different contractors serve different functions, including: (1) claims processing; (2) program integrity; (3) specialty medical review; (4) appeals; and (5) quality improvement.

Claims processing contractors are entities contracted by CMS to process provider enrollment applications, process claims submitted by health care providers/suppliers and make payments in compliance with Medicare regulations and policies. Currently, the claims processing entities include carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (MACs). Due to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, claims processing authority is currently being transitioned to the MACs. Much of the carrier, FI, and RHHI workload has already or will be shifted to MAC jurisdictions. The MACs perform various duties such as recovering overpayments on previously processed claims, handling provider enrollment issues, providing education on Medicare billing procedures, and resolving issues pertaining to submitted claims. Recently, CMS announced that MACs will also be responsible for issuing demand letters in connection with RAC identified overpayments beginning in January 2012.

Program Integrity contractors are responsible for identifying cases of suspected fraud. Specifically, the CMS contractors Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs) are in charge of implementing the Medicare Benefit Integrity program. PSCs and ZPICs use a variety of proactive and reactive techniques to identify and address potentially fraudulent billing practices. CMS is currently in the process of transitioning PSCs to ZPICs, who will soon perform all benefit integrity work. Seven ZPICs were created to perform program integrity for Medicare Parts A, B, C, D (prescription drugs), DME, Home Health and Hospice, and Medi-Medi.

CMS has contracted with the Recovery Audit Contractors (RAC) to carry out program integrity efforts. RACs conduct automated, semi-automated and complex reviews in an effort to identify and recover improper payments (i.e. underpayments and overpayments). There are four RAC regions, each with its own contractor: Diversified Collection Services (Region A), CGI (Region B), Connolly Consulting (Region C) and HealthDataInsights (Region D). The Tax Relief and Health Care Act of 2006 authorized the Recovery Audit program for Medicare Parts A and B. The Affordable Care Act expanded the program to Medicare Parts C and D, as well as to Medicaid. The Medicaid RAC program was created as a tool to fight Medicaid fraud and abuse, and the program shares some similarities with the Medicare RAC program. CMS released the final rule for the Medicaid RAC program on September 14, 2011.

Medicaid Integrity Contractors (MICs) contract with CMS to perform program integrity work. There are three types of MICs: Review MICs, Audit MICs and Education MICs. Review MICs are responsible for investigating potential provider fraud, waste, or abuse. Audit MICs are the Medicaid version of RACs in that they audit claims submitted by providers and identify improper payments. However, unlike the

RACs who are limited to a 3-year look back period, Audit MICs may review claims looking back up to five years. Education MICs are responsible for educating providers regarding payment integrity and quality-of-care matters.

Specialty Medical Review Contractors are tasked with preventing and minimizing improper payments. These contractors include the Medicare Coordination of Benefits Contractor (COBC) whose duties include with all activities that support the collection, management, and reporting of other insurance coverage of Medicare. Another specialty contractor is the Medicare Secondary Payer Recovery Contractor (MSPRC), which is responsible for recovering funds in which Medicare should not have been the primary payer. Finally, the National Supplier Clearinghouse (NSC) has been contracted by CMS to handle enrollment activities related to DME suppliers.

CMS has also contracted with entities to conduct first and second level provider appeals from claim denials. First level appeals (redetermination) are conducted by carriers, FIs, RHHIs, and MACs. For second level appeals (reconsideration), CMS has contracted with Quality Independent Contractors (QICs) who conduct independent reviews of the initial determination, redetermination and other issues related to payment of the appealed claim. There are seven QICs in total: two Part A QICs, two Part B QICs, one Part C QIC, one Part D QIC, and one DME QIC.

Administrative Law Judges (ALJs) constitute the third level of the appeals process. ALJ hearings may be conducted in-person, by video-teleconference (VTC) or by telephone. At the hearing, parties have an opportunity to present documentary evidence, legal arguments and witness testimony, which may include internal clinicians and experts. The ALJ will examine the issues, question parties and other witnesses, and review documents material to the issues. An ALJ's decision is based on the hearing record and is required to be made within 90 days from the date it received the request for hearing, unless the time period has been extended or waived.

If a provider is unsatisfied with the ALJ decision, it may appeal the decision to the Medicare Appeals Council (MAC). A MAC decision will typically be issued within 90 days of receipt of the request for appeal. The MAC's decision binds all parties unless the decision is later modified by a federal district court. If the MAC does not issue a decision, dismissal or remand within the required timeframe, the provider may request that the case be accelerated to federal district court.

Quality Improvement Contractors, known as Quality Improvement Organizations (QIOs), are private organizations (mostly not-for-profit) whose staff consists mostly of physicians and other health care professionals. Each state, as well as the District of Columbia, Puerto Rico and the Virgin Islands, has its own QIO. Their role of the QIO is to provide quality of care review services and implement quality improvement projects. QIOs are tasked with improving quality of care for beneficiaries and ensuring that the care is medically necessary, reasonable, provided in the appropriate setting, and in accordance with recognized health care standards.

While the audit landscape and numerous acronyms can be intimidating, providers are advised to arm themselves with knowledge about the roles of the various contractor entities. Understanding the focus of the various CMS audit contractors can provide significant insight if and when a provider receives a record request or initiates an audit of a provider's claims.

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