national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

World of Medicare Contractors

6/11/2025

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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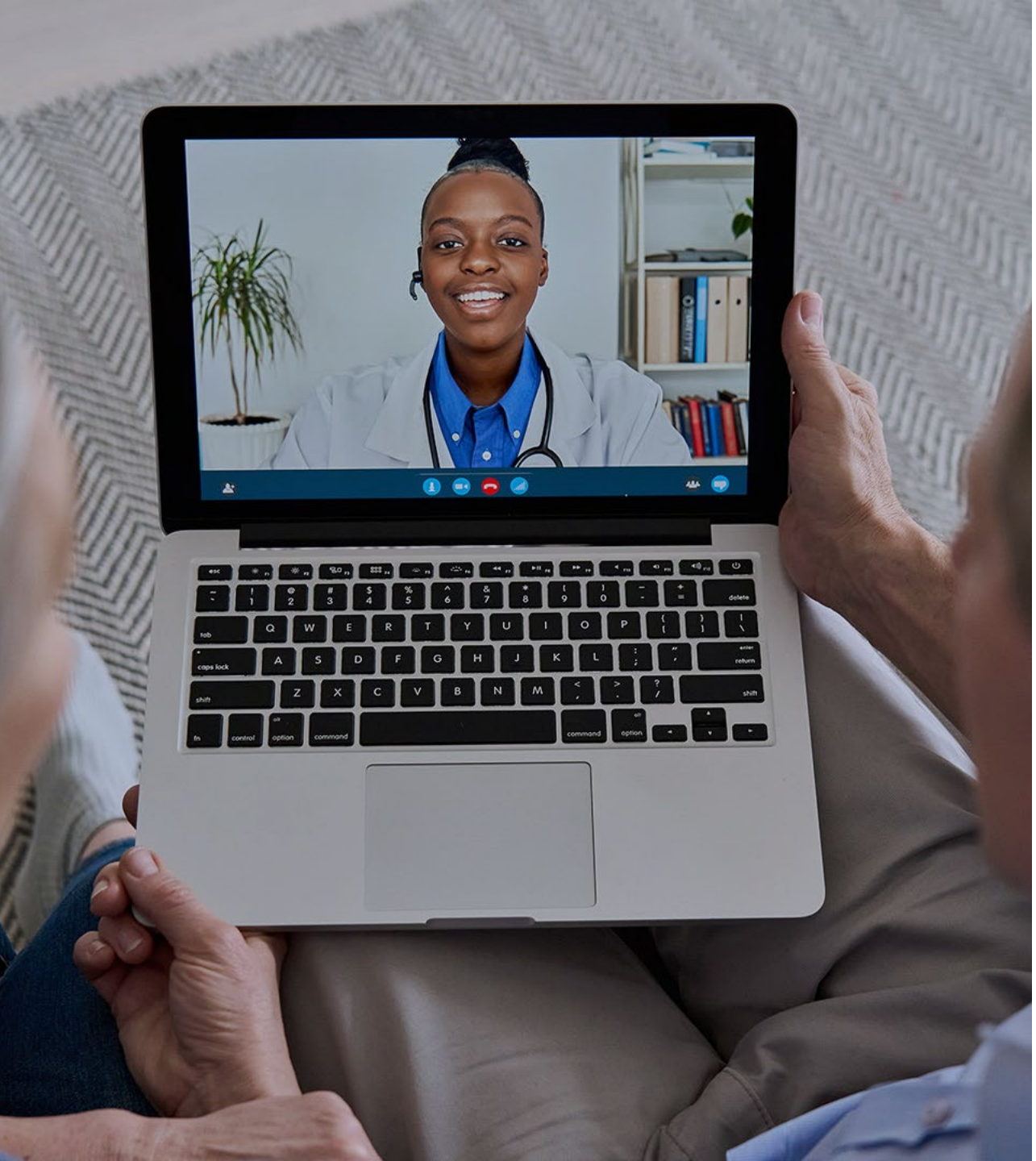

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Objective

After this session, attendees will understand the various contractors who work with the Medicare program, who they are, what they do and how to contact them.

Today's Presenter

- Andrea Freibauer
  - Provider Outreach and Education Consultant

Agenda

Introduction – CMS, MACs and More

Types of Contractors Within Medicare Program

- Contractors that work with providers
  - Enrollment
  - Claims processing and appeals
  - Auditing/claim review
- Contractors that work with beneficiaries
  - Enrollment, other payers
  - Customer Service
    - Claim questions
    - Quality of care
- Program integrity and oversight contractors
  - Fraud and Abuse

Centers for Medicare & Medicaid Services (CMS)

- Central office located in Baltimore, MD
  - Ten regional offices
- Oversees Medicare, Medicaid and SCHIP
- Establishes policies for paying health care providers
  - Responsible for writing Medicare rules and regulations (IOMs, transmittals)
- Assesses quality of health care facilities and services
- Assures Medicare run properly by contractors

CMS as Hub for Medicare Contractors

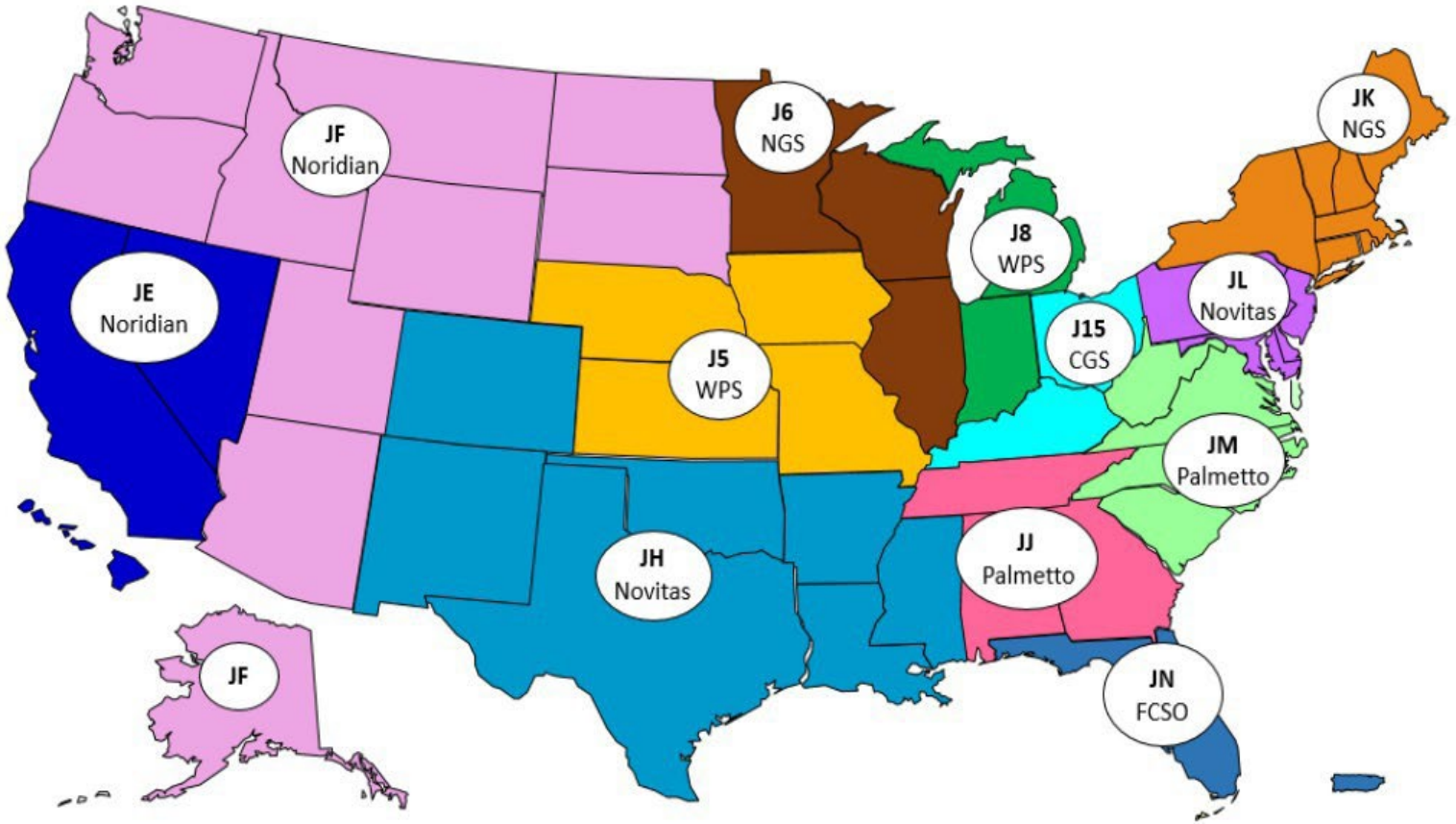
Social Security Administration (SSA)	Department of Health & Human Services (DHHS)		Department of Public Health Services (DPHS)
	CMS		
Benefits Coordination & Recovery Center (BCRC)	Medicare Administrative Contractors (MACs) - J6 & JK NGS -	Zone Program Integrity Contractors (ZPIC)	Office of the Inspector General (OIG)
Supplemental Medical Review Contractor (SMRC)	Quality Improvement Organization (QIO)	Recovery Audit Contractor (RAC)	Comprehensive Error Rate Testing (CERT)

MACs

- Private health care insurer awarded specific geographic jurisdiction
  - Multi-year contract with Federal government
- CMS: What's a MAC
- By the numbers
  - Twelve A/B MACs
    - Four of these A/B MACs also process HHH claims
      - HHH jurisdiction areas do not coincide with A/B MAC jurisdiction areas
  - Four DME MACs
    - Process Medicare DMEPOS claims for defined geographic jurisdictions

A/B MAC Jurisdictions

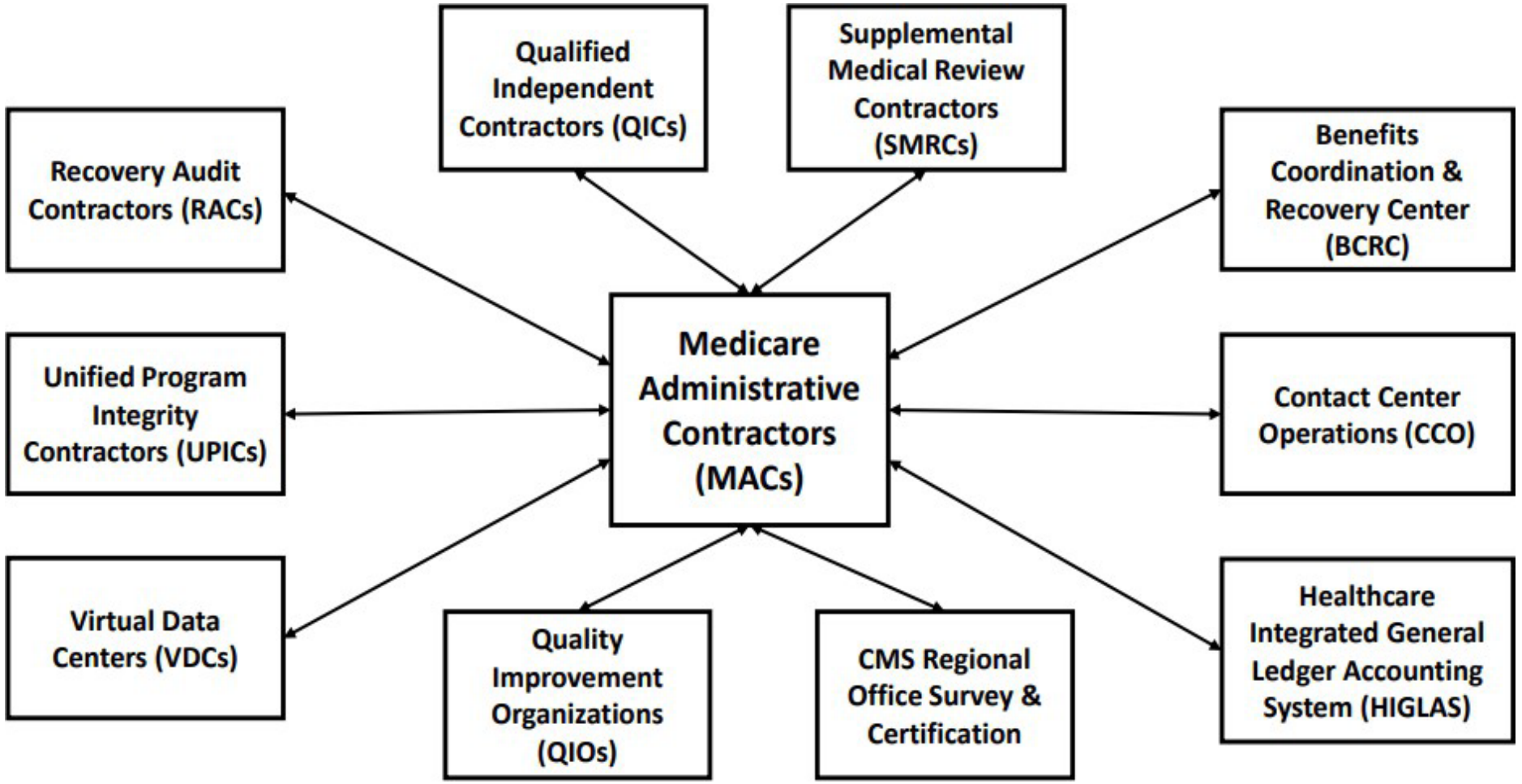
- CMS MAC Jurisdiction map



MAC Role and Responsibilities

- Enroll providers in Medicare FFS program
- Respond to provider inquiries
- Educate providers about Medicare FFS billing requirements
- Establish LCDs
- Review medical records for selected claims
- Process and pay Medicare FFS claims
- Ensure correct provider reimbursement
  - Includes auditing institutional provider cost reports
- Handle redetermination requests (first level of appeals process)
- Work with CMS and other Medicare contractors to administer full FFS operational environment

MACs and Other Contractors



MAC - National Government Services

- Jurisdiction 6 (J6) Region
  - Part A and B: IL, MN, WI
  - HHH: AK, AZ, CA, HI, ID, MI, MN, NV, NJ, NY, OR, WA, WI and U.S. Territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico and U.S. Virgin Islands
  - FQHC: 44 states, District of Columbia and five U.S. territories.
- Jurisdiction K (JK) Region
  - Part A and B: CT, ME, MA, NH, NY, RI, VT
  - HHH: CT, ME, MA, NH, RI, VT

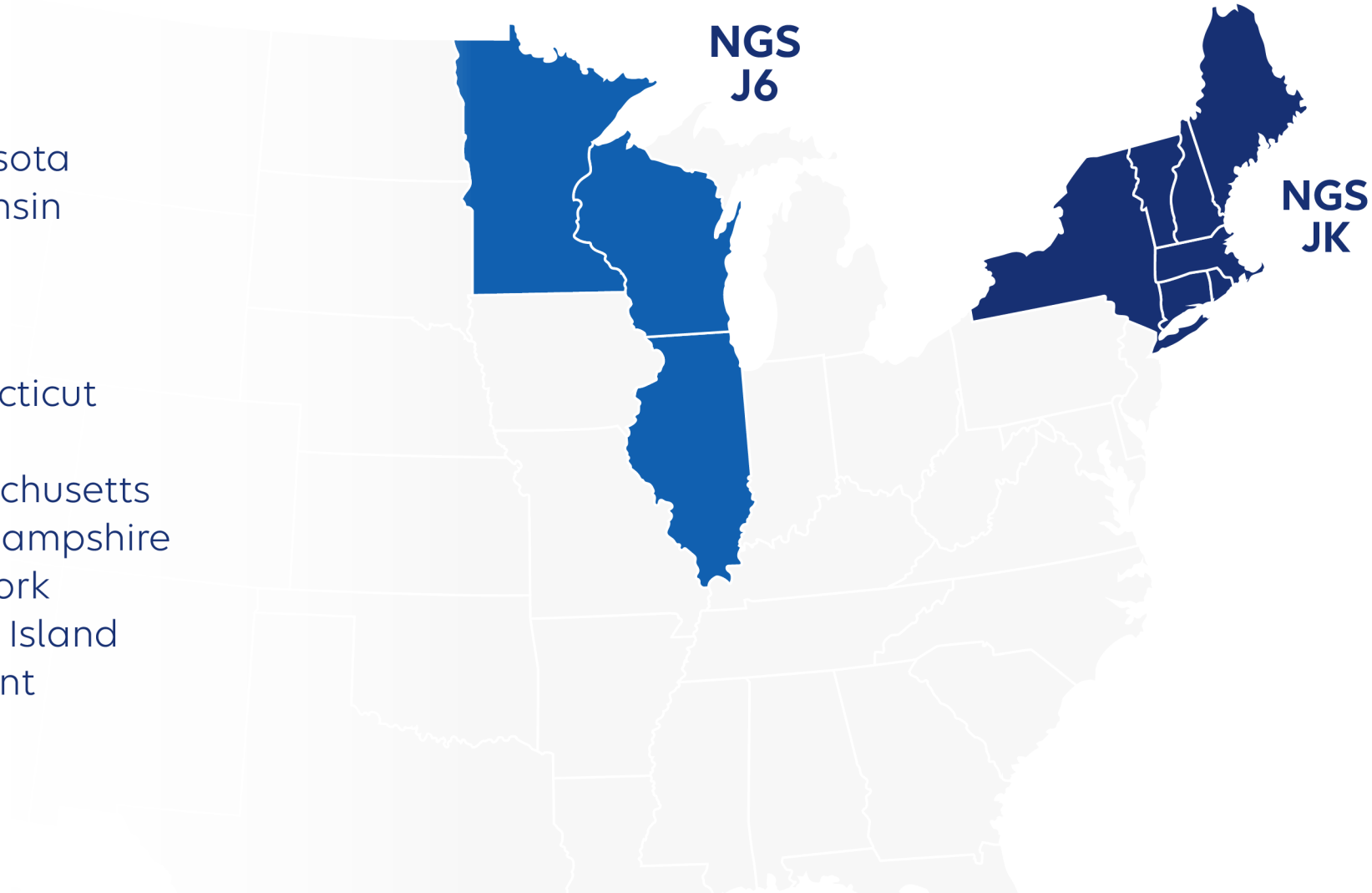
NGS Part A/B Jurisdictions

NGS J6

- Illinois
- Minnesota
- Wisconsin

NGS JK

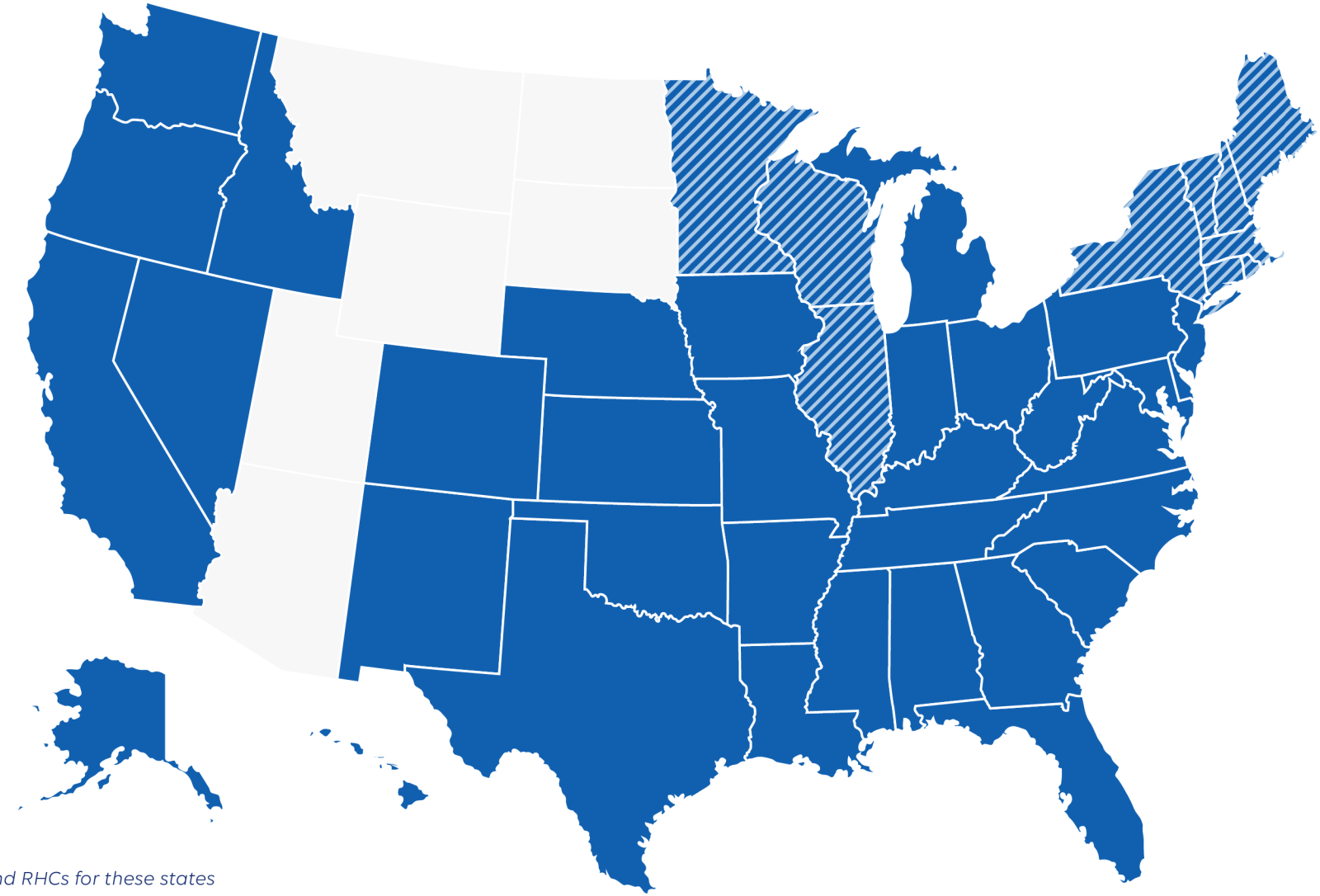
- Connecticut
- Maine
- Massachusetts
- New Hampshire
- New York
- Rhode Island
- Vermont



NGS FQHC-RHC

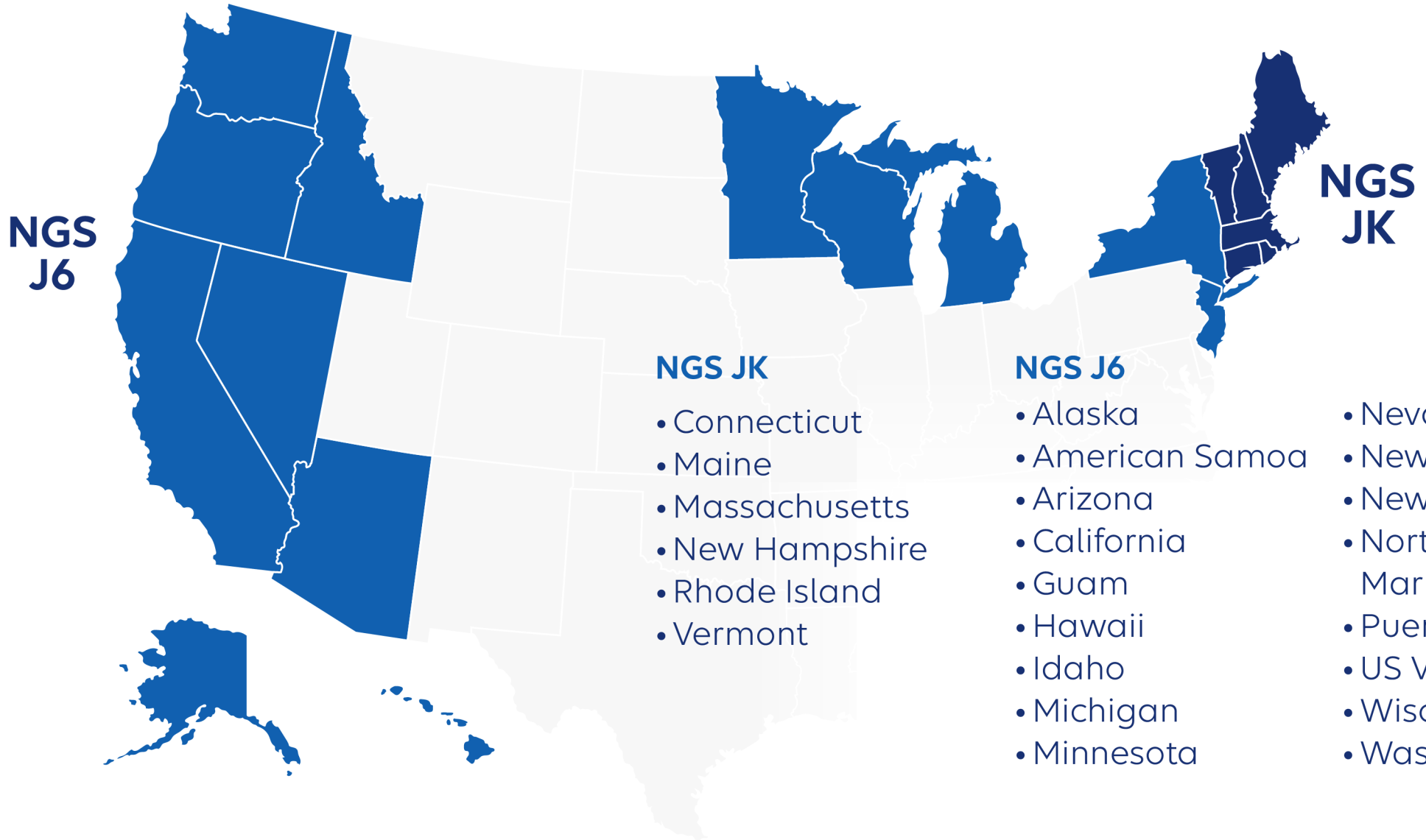
NGS J6 & JK

- Alabama
- Alaska
- American Samoa
- Arkansas
- California
- Colorado
- **Connecticut***
- Delaware
- Florida
- Georgia
- Guam
- Hawaii
- Idaho
- **Illinois***
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- **Maine***
- Maryland
- **Massachusetts***
- Michigan
- **Minnesota***
- Mississippi
- Missouri
- Nebraska
- Nevada
- **New Hampshire***
- New Jersey
- New Mexico
- **New York***
- North Carolina
- Northern Mariana Islands
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- **Rhode Island***
- South Carolina
- Tennessee
- Texas
- **Vermont***
- Virginia
- Washington
- Washington D.C.
- West Virginia
- **Wisconsin***



* *NGS is the MAC for FQHCs and RHCs for these states*

NGS Home Health & Hospice Jurisdictions



NGS JK

- Connecticut
- Maine
- Massachusetts
- New Hampshire
- Rhode Island
- Vermont

NGS J6

- Alaska
- American Samoa
- Arizona
- California
- Guam
- Hawaii
- Idaho
- Michigan
- Minnesota
- Nevada
- New Jersey
- New York
- Northern Mariana Islands
- Puerto Rico
- US Virgin Islands
- Wisconsin
- Washington

Appeals

- Five levels
  - Different contractor/entity for each level
  - Must go through levels in order
- MLN® Booklet: *Medicare Parts A & B Appeals Process*
- CMS website: Original Medicare (Fee-for-service) Appeals

Level One: Redetermination - NGS

- NGS appeals information
- Ways to submit appeal request to NGS
  - Submit an Appeal Electronically with NGSConnex
  - Submit an Appeal Electronically via esMD
  - Via mail – download/complete Part A Redetermination Request Form
    - Send to appropriate mailing address listed on form
- Additional appeal-related forms
- Appeals Calculator
- Tip Sheet for Medicare Providers on First Level of Appeals (Redeterminations)

Level Two: Reconsideration - QIC

QIC Jurisdiction	NGS Jurisdiction	Contractor
Part A East	JK	C2C Innovative Solutions, Inc.
Part A West	J6	Maximus, Inc.
Part B North	J6 and JK	C2C Innovative Solutions, Inc.
Part B South	n/a	C2C Innovative Solutions, Inc.
DME	n/a	Maximus, Inc

Appeal Levels Three, Four, and Five

- **Level Three**: ALJ
  - ALJ hearing request must be filed with OMHA
    - OMHA e-Appeal Portal allows electronic submission of Medicare Part A and B level three appeal requests only
      - Upload documentation, and obtain information on appeal status
- **Level Four**: Medicare Appeals Council Review through DAB
- **Level Five**: Judicial Review in Federal District Court
  - 42 CFR 405.1136

Medicare Audit and Review Contractors

Medicare Audit Contractors

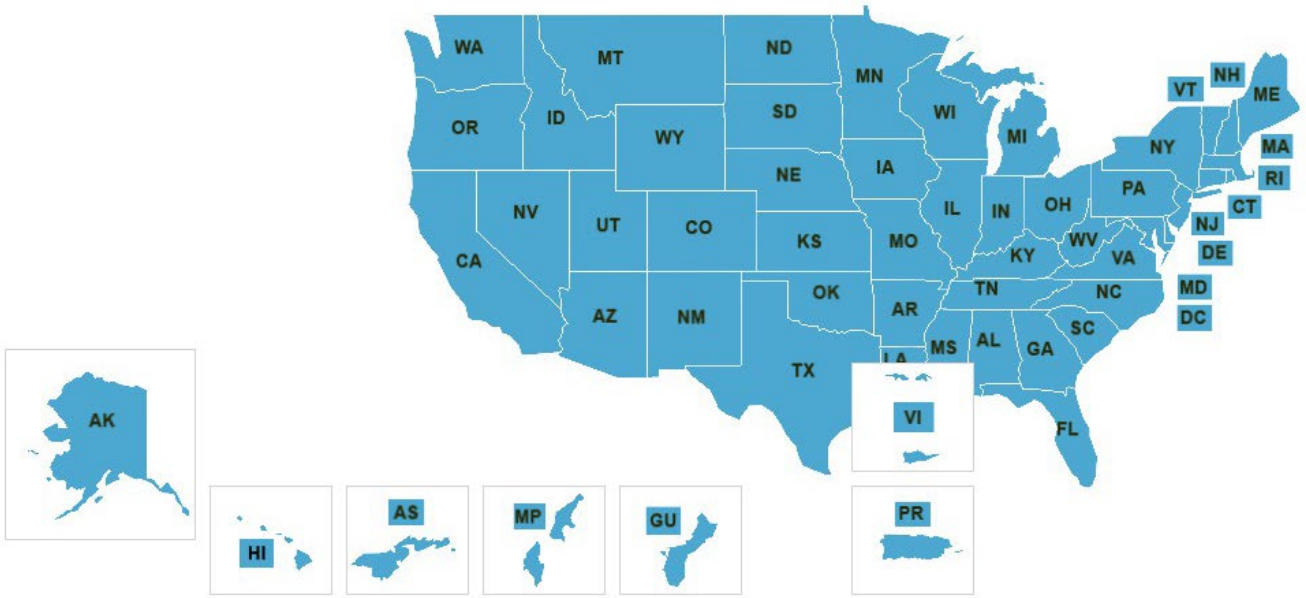
- CMS Center for Program Integrity (CPI) oversees various contractors' medical reviews and audits
  - Providing broad direction on medical review policy
  - Reviewing/approving Medicare contractors' annual medical review strategies
  - Facilitating Medicare contractors' implementation of recently enacted Medicare legislation
  - Facilitating compliance with current regulations
  - Ensuring Medicare contractors' performance of CMS operating instructions
  - Conducting continuous monitoring and evaluation of Medicare Contractors' performance
  - Provide ongoing feedback and consultation to contractors regarding Medicare program and medical review issues

CMS Audit Contractor Strategies

- Prevent improper payments through MAC and SMRC evaluation of program vulnerabilities and taking action to prevent identified vulnerabilities
- Correct past improper payments through post-payment claim review by Recovery Auditors
- Measure and pinpoint causes of improper payments by calculating specific error rates by CERT contractors
  - Service
  - Provider type
  - Contractor
- Recover improper payments
  - Improper payment may be due to coverage, coding, and/or billing errors

Review Contractor Directory

- Interactive map - Access state-specific CMS contractor contact information, including websites, email addresses and phone numbers



Select a State:

- Select a state -

NGS MAC Medical Review

- Medical Review department strives to
  - Increase provider compliance with coverage, documentation and coding requirements
  - Prevent, reduce, and measure improper payments
  - Identify and recover improper payments
- NGS TPE program goal to reduce costs related to improper payments and appeals through
  - Pre-pay and post-pay review
  - Medical review and education
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 1 - Medicare Improper Payments: Measuring, Correcting, and Preventing Overpayments and Underpayments

SMRCs

- Contracts with CMS to conduct nationwide medical review of Medicaid, Medicare Parts A/B and DMEPOS claims
- Goal: Lower improper payment rates and increase efficiencies
  - Evaluate medical records and related documents to determine whether claims in compliance with coverage, coding, and payment practices
    - May result in claim adjustments and/or overpayment recoupment
  - Identify provider noncompliance through research and analysis of data (e.g., profiling of providers, services or beneficiary utilization)
  - Notify CMS and individual billing entities of review findings identified and make appropriate recommendations for POE and UPIC referrals
  - Identify vulnerabilities - CMS data analysis, CERT program, professional organizations, and Federal oversight agencies (OIG/GAO)

SMRC and NGS Coordination

- SMRC
  - Serves as readily available source of medical information to provide guidance in questionable claim review situations
  - Provides clinical expertise and judgment to develop LCDs and internal MR guidelines and effectively focus MR on areas of potential fraud and abuse
  - Keeps up-to-date with medical practice and technology changes that may result in improper billing or program abuse
- NGS
  - Initiates claim adjustments and/or overpayment recoupment actions identified by SMRC using standard overpayment recovery process

Contact the SMRC

- Current SMRC: Noridian Healthcare Solutions
  - Contact Center: 833-860-4133
    - Monday - Friday: 8:30 AM – 6:00 PM ET (7:30 AM to 5:00 PM CT)
  - Email questions to: SMRCMail@Noridian.com
    - Make sure to include:
      - Project ID
      - NPI, PTAN, State
      - Question
      - Company/Organization
      - Contact Phone Number
- NGS Supplemental Medical Review Contractor page

RAC

- Contracts with CMS to identify, detect and correct improper payments made on claims for services provided to Medicare beneficiaries
- Goal: Assist CMS and MACs to implement actions to prevent future improper payments
- Review topics approved by CMS
  - Approved and proposed topics posted to website
- Two post-payment review categories
  - Automated - No medical record needed; based on review of claims
  - Complex - Medical record required; requests and reviews records
- Review process
  - May look back three years from date claim was paid
  - Uses same policies as MAC (NCDs, LCDs, CMS Manuals, CMS regulations)

RAC and NGS Coordination

- RAC has 30 days to complete review
- When overpayment identified, RAC submits claim adjustment to NGS
- NGS issues automated demand letter to initiate overpayment recovery
- If you agree with RAC determination, NGS issues recoupment offset on RA unless you submitted check or valid appeal
  - RA recoupment offsets identified on RA ANSI remark code N432 (adjustment based on recovery audit)

Contact the RAC

- Performant Recovery, Inc.
  - Region 1 includes JK: CT, IN, KY, MA, ME, MI, NH, NY, OH, RI, and VT
  - Region 2 includes J6: AR, CO, IA, IL, KS, LA, MO, MN, MS, NE, NM, OK, TX, and WI
    - Telephone 866-201-0580
    - Email: info@Performantrac.com
- Performant website includes:
  - Issues under review
  - Forms, sample documents and FAQs
  - Provider contact Information (review for accuracy)
- RAC information on NGS website and CMS website
  - Recovery Auditor Timeliness Calculator

CERT

- Two contractors:
  - CERT Review Contractor (RC)
    - Samples claims
    - Requests and receives all medical records
    - Reviews medical records
    - Compiles data (using CERT SC)
  - CERT Statistical Contractor (SC)
    - Calculates improper payment rates and amounts
    - Designs sampling strategy
- CMS Comprehensive Error Rate Testing (CERT)

CERT and NGS Coordination

- CERT contractor
  - Selects stratified random sample of claims submitted to all Part A/B MACs and DME MACs during each reporting period
  - Requests medical records from provider
  - Reviews claims and medical records
  - Determines whether claim and service processed correctly and comply with Medicare policies, procedures and guidelines
  - Contacts NGS when improper payment identified
- NGS
  - Recoups overpayments from provider
  - Provides additional payment to provider for underpayments

Calculating Improper Payment Rate

- If coverage criteria not met or provider fails to submit all documentation to support claim billed, counted as either total or partial improper payment
- Identified errors categorized into one of five major categories:
  - No documentation
  - Insufficient documentation
  - Medical necessity
  - Incorrect coding
  - Other
- CERT calculates annual Medicare FFS improper payment rate and publishes in Annual CERT Report
- Based on CERT review results, CMS calculates improper payment rates (national, contractor, and service-specific)
  - Note - improper error rate does not equal fraud rate

Contact the CERT Contractor

- Website: CERT C3HUB
- CERT Customer Service
  - Telephone: 443-663-2699 or Toll-Free Telephone: 888-779-7477
  - Email:
    - General questions certprovider@empower.ai
    - Medical records and passwords: certmail@empower.ai
- Claim status search using seven-digit claim identifier (CID)
  - C3HUB > Claim Status Search tab
- CERT Denial Finder on NGS website under Tools & Calculators

Contractors and Beneficiaries

SSA

- Works with beneficiaries
  - Medicare enrollment
  - Premium billing and payment
  - General Medicare questions (not claim-related)
  - Replacement Medicare cards
- Social Security Administration
  - Telephone number: 800-772-1213
- SSA: Manage your Medicare Benefits
- Beneficiary online access: Get Started with Medicare

Contact Center Operations (CCO)

- Contractor: Maximus Federal Services, Inc.
- Responds to inquiries from Medicare beneficiary population
  - Handles over 35 million customer inquiries each year for CMS programs
    - Examples: 1-800-MEDICARE and Health Insurance Marketplace
  - 24/7 customer service
  - Range of services and quality assurance across multiple customer contact channels
    - Telephone, mail, email, TDD/TYY, fax, and web chat
- Fact Sheet: Contact Center Operations Contract Award

BCRC

- Contracts with CMS to consolidate activities for collection, management, and reporting of other insurance for Medicare beneficiaries
  - Does not process claims or handle claim-specific inquiries
- Goal: Improve quality of healthcare for all people with Medicare
  - Identifies situations where Medicare should not be primary payer of claims
  - Maintains MSP records in CWF including most corrections
  - Coordinates payment process to prevent Medicare mistaken payments
- CMS Coordination of Benefits & Recovery Overview
- MLN® Booklet: *Medicare Secondary Payer*

BCRC and MAC Coordination

- MACs contact BCRC to request
  - Set up and/or validation of new MSP records in CWF using data from incoming MSP and conditional claims
  - Corrections to existing MSP records in CWF using explanatory coding (indicating reason Medicare primary) on incoming primary claims
- Beneficiaries and other parties may contact BCRC to report
  - Employment/insurance corrections to MSP records in CWF when no explanatory coding available for provider to report on claims
- Providers contact BCRC to ask
  - General MSP questions
  - Questions regarding secondary claim development questionnaires

BCRC Contact Information

- Providers
  - Do not contact BCRC to request set up of new or corrections to existing MSP records
  - May refer beneficiaries and other parties to BCRC when appropriate
- References:
  - MLN Connects® Newsletter 10/26/2023, *"Conditional Payment Claims: Continue to Submit to Your Medicare Administrative Contractor"*
  - Set Up a Beneficiary's Medicare Secondary Payer Record
  - Correct a Beneficiary's MSP Record
- BCRC Contact
  - 855-798-2627
  - TTY/TDD: 855-797-2627

QIO

- Goal: Improve health care quality, access, value and equity for people with Medicare
  - CMS Quality Improvement Organizations
- QIO program initiatives, each have different focus
  - Beneficiary and Family Centered Care QIO (BFCC-QIOs)
    - Supporting Medicare Beneficiaries with Timely Patient-Centered Care
  - Quality Innovation Network QIO (QIN-QIOs)
    - Quality improvement support for nursing home, community or OP care setting
  - Hospital Quality Improvement Contractors (HQICs)
  - American Indian Alaska Native Healthcare Quality Initiative (AIANHQI)
  - Opioid Prescriber Safety & Support initiative (OPSS)

QIO Core Functions

- Uses data to track health care quality improvements at local level
- Protects integrity of Medicare Trust Fund by ensuring that Medicare pays only for R&N services and goods provided in most appropriate setting
- Protects beneficiaries by expeditiously addressing individual complaints
  - Beneficiary complaints
  - Provider-based notice appeals
  - Violations of Emergency Medical Treatment and Labor Act (EMTALA)
  - Other related responsibilities as articulated in QIO-related law

Inter-Contractor Coordination

- Quality of care issues for repeated violations required to be referred to QIO, state licensing/survey and certification agency, or other appropriate entity in service area by
  - NGS (MAC)
  - CERT contractor
  - RAC
  - UPIC
  - SMRC

Contact the BFCC-QIO

BFCC-QIO	NGS Jurisdiction	Contact Information
Acentra Health	JK (CT, ME, MA, NH, RI, VT)	Telephone: 888-319-8452 (toll-free) 216-447-9604 (local)
Livanta	JK (NY) J6 (IL, MN, WI)	Telephone 866-815-5440 (NY) 888-524-9900 (IL, MN, WI) Correspondence mailing address (10/7/2024): BFCC-QIO Program Livanta LLC P.O. Box 2687 Virginia Beach, VA 23450

Program Integrity and Oversight Contractors

OIG

- Mission: Provide objective oversight to promote economy, efficiency, effectiveness, and integrity of HHS programs, as well as health and welfare of people they serve
  - Drive positive change
  - Fight waste, fraud and abuse
  - Improve efficiency of Medicare, Medicaid and over 100 other DHHS programs
- Offices include:
  - Office of Audit Services (OAS)
  - Office of Evaluation and Inspections (OEI)
  - Office of Investigations (OI)
  - Office of Counsel to the Inspector General (OCIG)
  - Mission Support and Infrastructure (MSI)

OIG Initiatives

- OIG Workplan
- Advanced data analytics and modeling
- Criminal, civil, and administrative investigations
  - Investigating Fraud, Waste and Abuse
- Compliance guidance and education
  - Facilitating Compliance in the Health Care Industry
- Technical expertise on program integrity issues
- Cyber security oversight

OIG Additional Information

- OIG website
- OIG Fact Sheet
- OIG Hotline webpage
  - Learn more about types of tips: Before You Submit a Complaint
  - File a complaint online
- Exclusions Program
  - List of individuals and entities excluded from Federally funded health care programs for a variety of reasons
    - Example - conviction for Medicare or Medicaid fraud

CMS Regional Office – Survey & Certification

- Division of Survey and Certification Operations
  - Part of Consortium for Quality Improvement and Survey and Certification Operations (CQISCO)
- CQISCO strives to improve health and quality of care via dual mission of quality improvement and quality assurance
  - Partners with Center for Clinical Standards and Quality
    - Field focal point for survey and certification
    - Quality improvement
    - Clinical and medical science issues and policies for agency's programs

UPIC

- Formerly known as ZPICs
  - Most, but not all, ZPIC work has been transferred to UPIC program
- Goal - Investigate potential Medicare fraud, waste, and abuse
  - Identifies program vulnerabilities and potentially fraudulent Medicare providers via data analysis, comprehensive problem identification and research
  - Investigates allegations of fraud, waste or abuse (providers, beneficiaries, MACs, OIG, CMS)
    - Prevents Medicare Trust Fund monies from being paid inappropriately
      - Prepayment or post payment medical review, payment suspensions and/or revocations
        - Requests medical records, conducts interviews and onsite visits
    - Initiates appropriate administrative actions when evidence of fraudulent activity
      - Referrals to MAC or law enforcement

MAC Role with UPIC

- MAC interacts with UPIC contractor in support of CMS audit, oversight, and anti fraud, waste and abuse efforts
  - Ensures claims processed accurately
  - Performs provider outreach and education
  - Screens complaints and refers cases of suspected fraud to UPIC
  - Recoups overpayments identified by UPIC
  - Handles initial appeals of UPIC decisions
- UPIC identifies improper payments and refers to MACs for recoupment

UPIC Contacts

UPIC	NGS Jurisdiction	Contact Information
CoventBridge Group - Midwest	J6 (IL, MN, WI)	Telephone: 614-801-0495 Mailing address: CoventBridge Group 2118 Southwest Boulevard Grove City, OH 43123
Safeguard Services, LLC (SGS) - Northwestern	JK (CT, ME, MA, NH, NY RI, VT)	Mailing address: SafeGuard Services LLC Suite 200 1250 Camp Hill Bypass Camp Hill, PA 17011

Provider Compliance Tips

Provider Responsibilities

- Verify all addresses are up-to-date with Medicare
  - Update by using PECOS or appropriate CMS-855 provider enrollment application
- Ensure your staff is familiar with Medicare coverage, documentation, and billing requirements
  - CMS website
  - IOMs
  - MCD
  - CMS Transmittals, MLN Matters Articles
  - CMS MLN® Publications & Multimedia
  - NGS website
  - NGS Medical Policies

Staff Roles and Accountability

- Determine which provider staff accountable for specific roles and ensure staff understanding of goals and objectives
  - Clinical staff knows where to find Medicare coverage guidelines and understands how to document appropriately
  - Billing staff must
    - Be aware of proper and current claim requirements
    - Should regularly check for any RTPs or rejects to determine issue(s) and correct
    - Understand Overpayment and Appeals processes
  - Mail room knows where medical record requests must be sent (appropriate staff) and that requests must be forwarded timely
  - Compliance staff tracks errors and ensures clinical/billing staff obtain education to prevent future errors

Medical Records and Documentation

- "If it wasn't documented, it wasn't done"
  - CMS YouTube Video - Provider Minute: The Importance of Proper Documentation
- Documentation must
  - Be complete and legible
  - Support services rendered/billed
    - Detail beneficiary's condition, treatment, and response to treatment
    - Clearly show medial necessity
    - Indicate services rendered compliant with Medicare rules and regulations

Respond Promptly to ADRs

- Staff should be familiar with documentation requests
- Required documentation lists (components required for review)
  - Contact information (may be in letter and/or on website)
- Respond timely to ADRs - typically within 45 days
  - Review request for details, timeframe, and address
- ADR response tips
  - Submitted in correct format or mailed to correct address
  - Ensure all relevant records submitted for DOS and service(s) requested
    - Including any documentation from third party (as appropriate)
  - Do not include additional correspondence with documentation submissions

Reminder

- Medicare and NGS have edits to ensure proper claim submission; however, it is impossible to edit for everything
- Just because claim paid does not necessarily mean it was paid appropriately

Be Proactve! Perform Self-Audits

- Compare medical records to billed claims
  - Use coverage criteria, LCD and billing/coding guidelines
- Ensure documentation legible, clear, and shows service meets Medicare medical necessary and coverage requirements
  - Ensure orders, treatment records, test results included
  - Signatures when required
- Educate staff with audit results
  - What was good/great - examples
  - Any deficiencies
  - Suggestions for improvement

CMS Resources

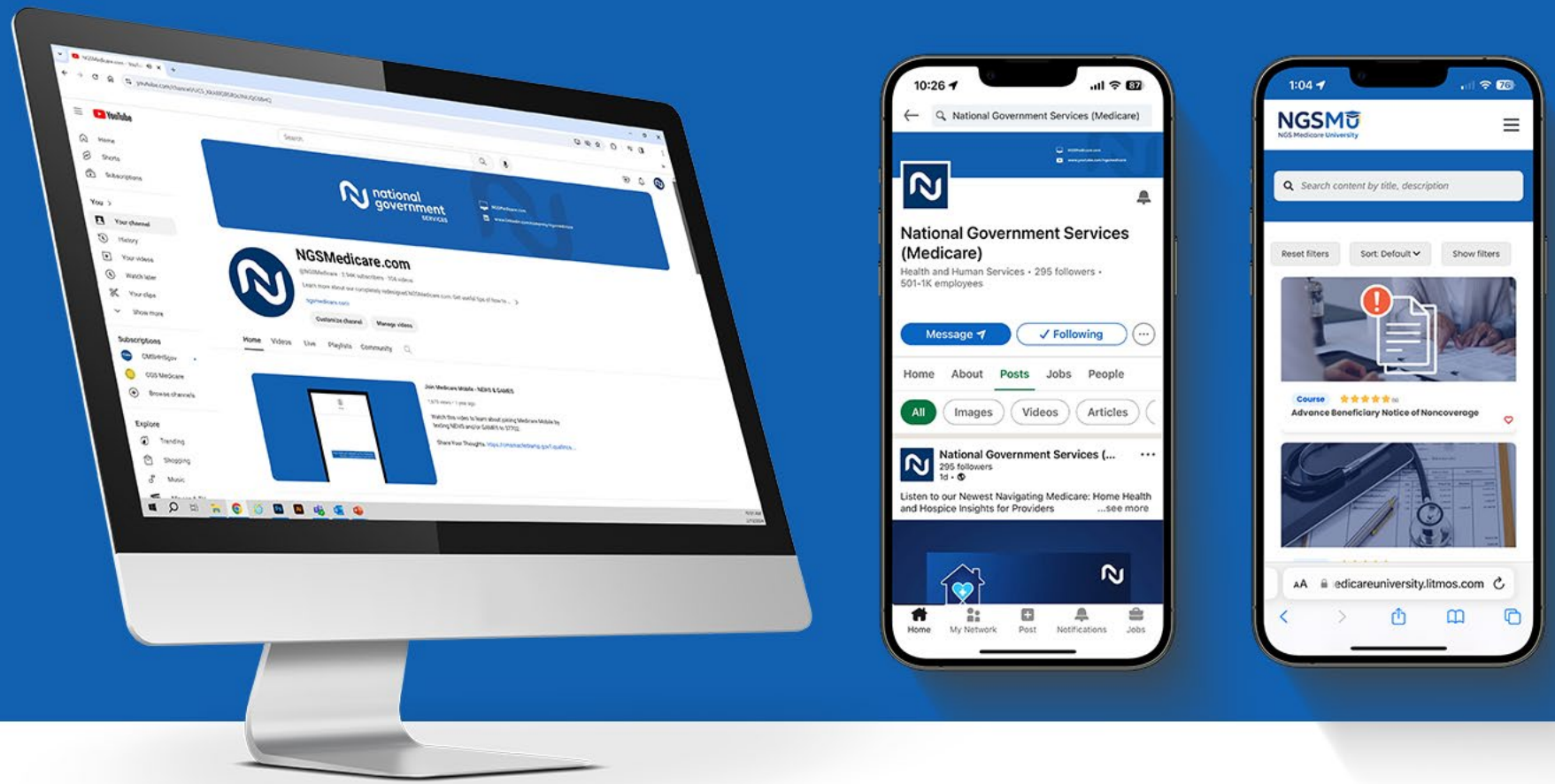
- CMS Medicare Fee-for-Service Compliance Programs
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*
- MLN® Educational Tool: *Medicare Provider Compliance Tips*
- MLN® Fact Sheets:
  - *Checking Medicare Eligibility (MLN8816413)*
  - *Complying with Medical Record Documentation Requirements (MLN909160)*
  - *Complying with Medicare Signature Requirements (MLN905364)*
  - *Medicare Overpayments (MLN006379)*
  - *Medicare Fraud & Abuse: Prevent, Detect, Report (MLN4649244)*

NGS Resources

- *Fundamentals of Medicare*
- Medicare Compliance
- Best Practices for a Successful Targeted Probe and Educate Review
- Methods for Responding to an ADR
  - *NGSConnex User Guide*
- Contact Us
- Subscribe to Email Updates
- Events

Questions?

Thank you!



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[YouTube Channel](#)
Educational Videos

[Medicare University](#)
Self-paced online learning

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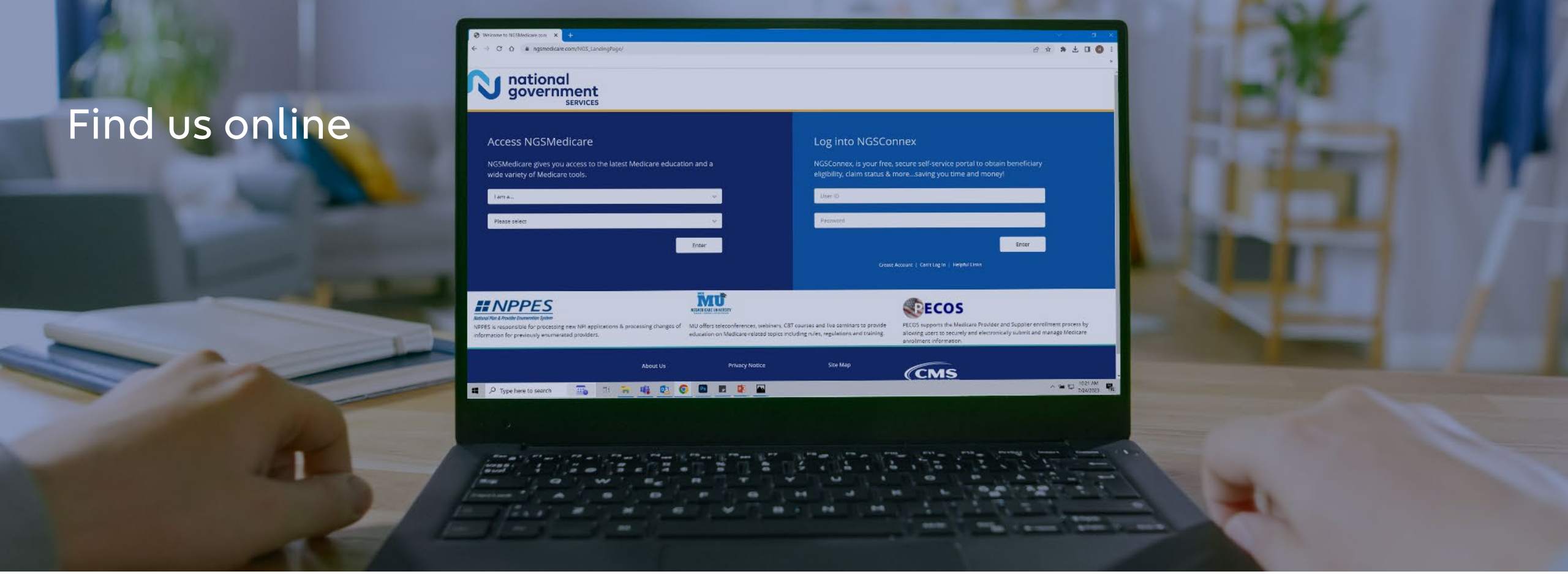
Educational Content

Find us online



www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

[IVR System](#)
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

[NGSConnex](#)
Web portal for claim information

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