



Medicare Physician Services Version

KEY CONCEPTS OUTLINE

Module 1: Medicare Overview and Contractors

I. The Four Parts of Medicare

A. Medicare Part A

1. Part A covers inpatient care, including:
 - a. Hospital care at a general acute care hospital, Critical Access Hospital (CAH), Inpatient Rehabilitation Facility, Inpatient Psychiatric Facility, or Long Term Acute Care Hospital (LTCH);
 - b. Care at a Religious Nonmedical Health Care Institution;
 - c. Skilled Nursing Facility (SNF) care;
 - d. Home Health care (under a home health plan of care);
 - e. Hospice care. <Medicare.gov, "What Part A covers" website>
2. These facilities are referred to as "providers" under the Medicare regulations. <42 C.F.R. 400.202>
3. The beneficiary generally doesn't pay a premium for Part A if they, or their spouse, paid Medicare taxes. <Medicare.gov, "Part A costs" website>
 - a. If an individual doesn't qualify for premium free Part A benefits, they can purchase them. To purchase Part A, the beneficiary must generally also purchase Part B and may have to meet certain other requirements. <Medicare.gov, "Part A costs" website>
4. Institutional providers bill Part A services to the Medicare Administrative Contractor (MAC) using the UB-04/837I claim format. <Medicare Billing: 837I and Form CMS-1450 Fact Sheet>
 - a. Course note: The MAC is discussed later in this outline. The UB-04/837I format is discussed in a later module.

B. Medicare Part B

1. Part B covers inpatient, outpatient, and medical care, including:
 - a. Outpatient hospital diagnostic and non-diagnostic (therapeutic) services;
 - b. Certain inpatient hospital services, discussed in a later module;
 - c. Certain SNF¹ and Home Health² services;
 - d. Preventative services provided to inpatients or outpatients;
 - e. Physician and other professional services, including outpatient therapy;
 - f. Ambulatory Surgery Center (ASC) services;
 - g. Independent Diagnostic Testing Facility (IDTF) and Clinical Diagnostic Laboratory services; and
 - h. Durable Medical Equipment (DME). <Medicare.gov, "What Part B covers" website>
2. These services can be provided by institutional "providers" or "suppliers", including physicians and other non-institutional providers. <42 C.F.R. 400.202>
3. The beneficiary generally pays a premium for Part B. <Medicare.gov, "Part B costs" website>
 - a. The beneficiary may purchase Part B, even if they are not eligible for or do not purchase Part A.

Medicare beneficiaries may have both Part A and Part B or just Part A or just Part B. Enrollment should be verified
4. Institutional providers bill Part B services to the MAC on the UB-04/837I claim format. <Medicare Billing: 837I and Form CMS-1450 Fact Sheet>
 - a. Physicians and other non-institutional suppliers bill Part B services to the MAC using the CMS 1500/837P claim format.

¹ SNF services provided to non-inpatient beneficiaries, provided to beneficiaries not in a covered Part A stay, or excluded from the Part A prospective payment system.

² Home Health services provided outside a plan of care.

C. Medicare Part C

1. Medicare Part C is an alternative to traditional fee-for-service Medicare Part A and B. Private insurance companies offer Part C in the form of Medicare Advantage (MA) plans. <Medicare.gov, “Your Medicare coverage choices” website>
2. MA plans may be Coordinated Care Plans (CCPs), Medical Savings Account (MSA) plans, and Private Fee-for-Service (PFFS) Plans. <Medicare Managed Care Manual, Chapter 1 § 20.1>
 - a. Coordinated Care Plans may take the form of Health Maintenance Organizations (HMOs) that use a network of providers and a primary care provider gatekeeper, Local and Regional Preferred Provider Organizations (PPOs), and Special Needs Plans (SNPs) for institutionalized beneficiaries (I-SNPs), dual eligible beneficiaries (D-SNPs) and beneficiaries with a severe or disabling chronic condition (C-SNPs).
3. MA plans must cover as basic benefits all services traditional Medicare covers, except hospice care, applying coverage criteria that are no more restrictive than traditional Medicare coverage criteria. <42 C.F.R. 422.101(a); 88 Fed. Reg. 22185-200>
 - a. Traditional Medicare covers hospice care for beneficiaries covered by MA Plans, except plans participating in the Value-Based Insurance Design Model with the Hospice Benefit Component. <Medicare.gov, “What Medicare health plans cover” website; cms.gov, “VBID Model Hospice Benefit Component Overview”>

Link: Medicare Advantage Value Based Insurance Design – Hospice Model under Medicare-Related Sites – Advantage Plans
4. MA plans may cover additional services not covered under traditional Medicare as supplemental benefits if they are primarily health related and are not for comfort, cosmetic purposes, or daily maintenance. <Medicare Managed Care Manual, Chapter 4 § 30.1>
 - a. Examples of supplemental benefits include
 - i. Vision, hearing, dental, or preventative services not covered by Medicare <Medicare Managed Care Manual Chapter 4 § 30.2>;
 - ii. Bathroom safety devices, fitness benefits, health and nutritional education and weight management programs, meals on a temporary basis after surgery or for a chronic condition, over the counter

supplements and drugs, remote access technology such as a nurse hotline, and transportation services. <Medicare Managed Care Manual, Chapter 4 § 30.3>; and

- iii. Services furnished by a different type of provider or in a different setting than basic benefits (i.e., as covered under traditional Medicare). <88 Fed. Reg. 22186-7, 22192, 22195>
- b. MA Plans may make beneficiaries aware of treatment options and settings under their supplemental benefits or encourage specific treatment options as part of the plan's coordination and management of the care. <88 Fed. Reg. 22195>
- 5. MA plans pay hospitals according to their contract with the hospital or, if they are not contracted with the hospital, they must generally pay the hospital at least the traditional Medicare payment rate. <MA Payment Guide for Out of Network Payments, 4/15/2015 Update>
 - a. Medicare publishes a very helpful guide for payments by MA plans to out of network providers on their "Provider Payment Dispute Resolution for Non-Contracted Providers" website.

Link: Medicare Advantage Out of Network Payment Guide under Medicare-Related Sites – Advantage Plans

D. Medicare Part D

- 1. Part D covers prescription drugs for Medicare beneficiaries. Part D plans are designed to cover drugs obtained from a retail pharmacy.
 - a. Part D may cover drugs, not covered under Part B, provided in an outpatient/office setting. If the physician is not contracted with the Part D plan, the beneficiary may have to request out of network reimbursement from their Part D plan.

II. Medicare Administrative, Program Integrity, and Appeal Contractors

A. The Centers for Medicare and Medicaid Services (CMS) use multiple functional contractors to perform the functions necessary to administer the Medicare program.

B. Part A/B Medicare Administrative Contractors (MACs)

1. MACs are Medicare contractors who perform all core claims processing functions and act as the primary point of contact for providers and suppliers for functions such as enrollment, education, coverage, billing, processing, redetermination requests, payment, and auditing. <CMS.gov, "What is a MAC" website>
 - a. MACs publish substantial claims processing, billing, and coding guidance on their websites, including medical review and documentation guidelines, coverage policies, and appeals and audit information.

Tip: Medicare contractors sometimes refer to hospital outpatient services as "Part B of A" or simply Part A outpatient services. Policies and guidance for outpatient services are found on MAC Part A websites even though these services are covered under Part B.

2. There are 12 Part A/B MACs, designated by either a letter or number. <See "Medicare Administrative Contractors (MACs) As of June 2021"; see "A/B Jurisdiction Map as of June 2021">

In 2010, CMS began consolidating the original 15 MAC jurisdictions (designated by numbers) into 10 consolidated MACs (designated by letters). In 2014, after consolidating 12 jurisdictions, CMS discontinued the consolidation leaving four numbered jurisdictions (J5, J6, J8, and J15).

- a. CMS publishes a map with state-by-state contractor information.

Link: Medicare Contractor Interactive Map under Medicare-Related Sites - General

C. Recovery Audit Contractors/Recovery Auditors (RAC)³

1. CMS identified 4 Part A/B Recovery Audit Jurisdictions (i.e., Regions 1-4).
<See "A/B Recovery Audit Program Regions">
2. CMS contracts with one Recovery Auditor for each jurisdiction, who is paid a contingency fee based on identified overpayments and underpayments.
<CMS.gov, "Medicare Fee for Service Recovery Audit Program" website>
3. CMS publishes all proposed and approved audit topics on their website.

Link: Medicare Fee for Service Recovery Audit Program, under Medicare-Related Sites - General

4. Recovery Auditors have a three year look back period, from the claims paid date to the date of the medical record request (for complex reviews) or the overpayment notification letter (for automated reviews). <Statement of Work (SOW) for the Part A/B Medicare Fee-for-Service Recovery Audit Contractor (RAC)>
5. Recovery Auditors can make a limited number of Additional Documentation Requests (ADRs) for medical records from a physician/non-physician practitioner each 45-day period.
 - a. The limits will be based on the servicing physician or non-physician practitioner's billing Tax Identification Number (TIN), as well as the first three positions of the ZIP code where that physician/non-physician practitioner is physically located. <See: Physician/Non-Physician Practitioner Additional Documentation Limits>
 - b. ADR limits will be based on the number of individual rendering physicians/non-physician practitioners reported under each TIN/ZIP combination in the previous calendar year. <See: Physician/Non-Physician Practitioner Additional Documentation Limits>
 - i. A physician group has one TIN and two physical locations (in locations with zip codes that share the first three digits) qualifies as a single entity.
 - ii. A physician group with one TIN and two physical locations (not sharing zip code digits) qualifies as two unique entities.

³ CMS uses the terms Recovery Auditor and Recovery Audit Contractor (RAC) interchangeably.

- c. For details on how ADR limits are calculated, refer to the Resources page of the Recovery Audit Program site in the document link labeled ADR-Limits-Institutional-Provider (Facilities)-May 1, 2022 (PDF).
- i. Example: Group size -50 or more practitioners – maximum number of requests per 45 days is 50.

D. Unified Program Integrity Contractors (UPICs)

1. Unified Program Integrity Contractors (UPICs) combine and integrate the functions of the former Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs) and Medicaid Integrity Contractors (MICs). <CMS.gov, Review Contract Directive Interactive Map Page>
2. The UPICs perform integrity related activities (e.g., investigations and audits) associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi) in five geographic jurisdictions. <CMS.gov, Review Contract Directive Interactive Map Page>

In performing fraud and abuse functions, UPIC may:

- Conduct investigations and perform medical review
- Perform data analysis
- Request medical records and documentation
- Conduct interviews with beneficiaries, complainants, or providers
- Conduct site verification or onsite visits
- Identify the need for a prepayment or auto-denial edit
- Share information with other UPICs/ZPICs
- Institute a provider payment suspension
- Refer cases to law enforcement to consider civil or criminal prosecution

E. Comprehensive Error Rate Testing Program Contractor (CERT)

1. CMS contracts with CERT contractors to perform audits to measure the error rate of Medicare paid claims. <CMS.gov, "Comprehensive Error Rate Testing" website>
 - a. The CERT contractor uses a statistically valid random sample of approximately 50,000 claims to determine a national improper payment rate for the Medicare program. <CMS.gov, "Comprehensive Error Rate Testing" website>

b. The CERT contractor assigns one of the following improper payment categories:

i. No Documentation

ii. Insufficient Documentation

iii. Medical Necessity

iv. Incorrect Coding

v. Other

a) Examples include duplicate payment error and non-covered or unallowable service

F. Supplemental Medical Review Contractors (SMRCs)

1. CMS contracts with SMRCs to perform and provide support for a variety of tasks, including nationwide medical review audits aimed at lowering improper payment rates by conducting reviews focused on vulnerabilities identified by CMS. <CMS.gov, "Supplemental Medical Review Contractor" website>
2. SMRC's conduct medical reviews selected based upon multiple sources of information including, but not limited to:
 - a. CMS identified vulnerabilities;
 - b. OIG/GAO (Office of Inspector General/Government Accountability Office) identified issues; and
 - c. Comprehensive Error Rate Testing (CERT) Errors. <Medicare Program Integrity Manual, Chapter 1 § 1.3.1>

G. Quality Improvement Organizations (QIOs)

1. Beneficiary and Family Centered Care QIOs (BFCC-QIOs) manage beneficiary complaints and quality of care reviews, including beneficiary discharge appeals. <CMS.gov, "Quality Improvement Organizations" website; CMS.gov, "Inpatient Hospital Reviews" website; 80 *Fed. Reg.* 39350-53>
2. CMS contracts with two BFCC-QIOs, KEPRO and Livanta, to provide services in 10 distinct areas designated by CMS. For details, refer to the QIO map included in the materials behind the outline. <See "QIO MAP">

3. Short Stay Reviews

- a. One of the QIOs, Livanta (now Accentra, renamed), was awarded a national contract to conduct short stay reviews (SSRs) and higher weighted DRG reviews in all QIO jurisdictions.
- b. Livanta has posted a schedule of the weeks they will request medical records for SSRs in 2025, included in the materials behind the outline.

Link: QIO Livanta Provider Resources under Medicare-Related Sites - Hospital

- c. Livanta has posted "Claim Review Advisors" that address the following topics:
 - i. Guidelines for conducting SSRs;
 - ii. Sampling strategy and a sample medical record request; and
 - iii. Clinical scenarios such as chest pain, atrial fibrillation, and congestive heart failure, are available on the Livanta Provider Resources page. <Livanta National Claim Review Contractor website>

- 4. Providers can sign up to receive information from Livanta, including Claim Review Advisors, Provider Bulletins, and other publications.

- 5. Note: Livanta's National Claim Review contract concluded on August 11, 2025

- a. Short Stay Reviews (SSR) will be conducted by the Medicare Administrative Contractors (MACs) beginning September 1, 2025.
 - i. Inpatient Hospital short stay patient status reviews for acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities will transition from the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations' (QIOs) (BFCC-QIO) to the MACs.
 - a) MACs will perform reviews on a sample of Medicare pre-payment Part A claims as part of our current Targeted Probe and Educate (TPE) program.
- b. Livanta will perform Higher Weighted Diagnosis-Related Group (HWDRG) for CMS regions 2, 3, 4, 7, 9.

Link: Livanta Claims Review Advisors under Listserv Subscriptions

H. Qualified Independent Contractors (QICs)

1. QICs conduct the second level of appeal if the MAC denies the providers first level appeal. <CMS.gov, "Second Level of Appeal: Reconsideration by a Qualified Independent Contractor" website>

III. Independent Government Entities

A. Departmental Appeals Board (DAB)

1. DAB is an agency within the Department of Health and Human Services that provides independent review of disputed decisions in a wide range of Department programs under more than 60 statutory provisions. <DAB Website, Background>
2. The two primary divisions of DAB with respect to Medicare disputes and appeals are:
 - a. Office of Medicare Hearings and Appeals (OMHA);
 - i. The Administrative Law Judges (and attorney advisors) are employed directly by the Office of Medicare Hearings and Appeals (OMHA).
 - ii. ALJs issue third level appeal decisions following an appeal of a decision of the QIC.
 - b. Medicare Appeals Council (often referred to as either "MAC" or the Council)
 - i. The Council provides the final administrative review (fourth level of appeal) of claims for entitlement to Medicare and individual claims for Medicare coverage and payment filed by beneficiaries or health care providers/suppliers appealed from the ALJs.

B. Department of Health and Human Services Office of Inspector General (OIG)

1. The DHHS OIG is the largest inspector general's office in the Federal Government, with the majority of their resources directed at oversight of the Medicare and Medicaid programs. <About OIG, HHS OIG website>
2. The DHHS OIG conducts nationwide audits, investigations, and evaluations; publishes an annual work plan of audit activity; provides cost saving and policy recommendations; and develops and distributes resources to assist health care providers with compliance with fraud and abuse laws. <About OIG, HHS OIG website>

IV. Key Sources of Authority (i.e., Medicare “Rules”)

- A. For your reference Handout 4 contains a listing of each of the types of source authority that will be discussed, as well as where it is published, where to find it on the web and example citations.

B. Statutes

1. Public Laws

- a. Congress adopts new statutes as Public Laws. Public Laws are found on Congress.gov, maintained by the Library of Congress.
- b. Refer to the “Congress.gov” link under the “Regulations and Statutes” section on HCPro’s links page.
- c. Each public law has a home page that provides information on the adoption of the bill and the final text.
 - i. Note: Under the “Text” tab, use the “Enrolled Bill” for an easy to use version of the text of a bill, with embedded links to related provisions.

2. *United States Code (U.S.C.)*

- a. The *U.S.C.* is a compilation of the statutes of the United States.
 - i. Title 42 of the *U.S.C.*, which contains the Medicare laws, has not been enacted as positive law. Its text is prima facie evidence of the law, but the text of the Public Law, as enacted, takes precedence in the event of a conflict.
- b. Refer to the “United States Code (Federal Statutes)” link under the “Regulations and Statutes” section on HCPro’s links page.

3. Social Security Act

- a. Frequently, Medicare laws are cited by their Social Security Act section number, rather than their *U.S.C.* section number. The Social Security Administration maintains an updated version of the Social Security Act.
- b. Refer to the “Social Security Act, Title 18 (Medicare)” link under the “Regulations and Statutes” section on HCPro’s links page.
- c.

C. Regulations

1. *Federal Register*

- a. CMS adopts new regulations in the *Federal Register*.
 - i. Typically, regulations are first published as proposed rules, with a request for public comment. After gathering the comments, the agency publishes a final rule responding to the comments in the preamble of the rule and adopting the final regulations.
- b. Refer to the "Federal Register" link under the "Regulations and Statutes" section on HCPro's links page.
 - i. Note: On this page, you can browse by date or use the "Search the Federal Register by citation" link on the left navigation area to search for a particular volume and page number.
- c. CMS also makes display copies of important proposed and final rules, along with accompanying data files and tables, available on their website.
 - i. Refer to the "Physician Fee Schedule -Regulations" link under the "Medicare Related Sites – Physician" section on HCPro's links page.

D. Sub-Regulatory Guidance

1. Sub-regulatory guidance such as manuals and transmittals is not binding on Medicare contractors or Administrative Law Judges (ALJs). Regulations require they give "substantial deference" to the guidance applicable to a case and if they do not follow it, explain why in their decision letter. <42 C.F.R. 405.1062>
2. CMS Manuals – published on the CMS web site.
 - a. "Paper-based" Manuals
 - i. The Provider Reimbursement Manual, containing charging and cost reporting guidelines, is available in a "paper-based" manual version and must be downloaded from the "Paper-Based Manuals" web site.
 - ii. Refer to the "Manuals – Paper Based Manuals" link under the "Medicare Related Sites – General" section on HCPro's links page.
3. "Internet-only" Manuals (IOM)

- a. The following IOM manuals should be of particular relevance for questions relating to Medicare coverage, coding, billing, and payment for hospital and physician services.
 - i. *Pub. 100-2 – Medicare Benefit Policy (basic coverage rules)*
 - ii. *Pub. 100-3 – Medicare National Coverage Determinations (national coverage decisions)*
 - iii. *Pub. 100-4 – Medicare Claims Processing*
 - iv. *Pub. 100-05 – Medicare Secondary Payer Manual provides information related to Medicare as a primary or secondary payer.*
 - v. *Pub. 100-08 – Medicare Program Integrity Manual provides information regarding policies and responsibilities for contractors tasked with medical review.*
 - b. Caution: CMS often removes or revises manual sections without providing an archive of prior versions. Providers should retain their own copy (printed or electronic) of manual sections they rely on for policy decisions.
4. CMS Transmittals and Program Memoranda – published on the CMS web site
- a. Transmittals communicate new or revised policies or procedures, as well as new, deleted or revised manual language.
 - i. Program Memoranda were used prior to October 1, 2013 to communicate information similar to transmittals.
 - b. Refer to the “Transmittals and Program Memoranda” link under the “Medicare Related Sites – General” section on HCPro’s link page.
 - i. Note: Use the links on the left navigation area to access transmittals or program memoranda from prior years.
 - c. Transmittals are numbered with an “R” followed by a sequential number distinct to the transmittal and two or more letters representing the manual the transmittal is associated with (e.g., CP for Claims Processing).
 - i. Transmittals with the OTN designation are global in nature and not tied to a particular substantive manual.
 - d. Transmittals are linked to a change request (CR) number, CMS’ internal tracking number, tying together documents associated with a particular policy change. CMS representatives often use the CR number rather than transmittal number when referring to policy changes.

- i. A single CR may be associated with multiple transmittals if the policy represented by the CR affects multiple manuals, for example one change request may have an associated *Medicare Claims Processing Manual Transmittal* and a *Medicare Benefit Policy Manual Transmittal*.
 - ii. The CR number is also used in the numbering of associated *MLN Matters Articles*, discussed later in this outline.
- e. Components of a Transmittal
 - i. "Date" (in the header) represents the date the transmittal was published.
 - ii. "Effective Date" represents the date of service the policy in the transmittal will begin to apply, unless noted otherwise.
 - a) **Caution:** The effective date of a transmittal may be prior to the date the transmittal was published, which may affect coverage, coding, billing, or payment of services already rendered.
 - iii. "Implementation Date" represents the date processing systems will be able to process claims correctly according to the policies in the transmittal, unless noted otherwise.
 - a) **Caution:** The implementation date is generally the first business day of the quarter or year after the transmittal is effective, but may be substantially after the effective date. A provider may need to hold claims affected by the transmittal until system changes are implemented.
 - iv. If there are new, deleted, or revised manual sections associated with the transmittal, they will be listed in the "Changes in Manual Instructions" table at the beginning of the transmittal.
 - v. The text of new or revised manual sections will appear after the attachments at the end of the transmittal.

E. MLN Matters Articles

- 1. There are two types of MLN Matters Articles:
 - b. MLN Matters Articles are articles that explain Medicare policy in easy to understand format, often written for specific provider types as noted at the top of the article.

- c. Refer to the “MLN Matters Articles – Overview Page” link under the “Medicare Related Sites – General” section on HCPro’s links page.
- d. There are two types of MLN Matters Articles:
 - i. MLN Matters Articles linked to a particular transmittal are intended to provide practical and operational information about the transmittal.
 - a) MLN Matters Articles linked to transmittals are numbered “MM” followed by the CR number for the transmittal.
 - b) Note: In addition to being published on the MLN website, a link for MLN Matters Articles associated with a transmittal appears below the link for the transmittal on the transmittal’s home page.
 - ii. Special Edition MLN Matters Articles are not linked to a transmittal but rather provide information on topics CMS believes require additional clarification. They frequently provide information not found in transmittals or manuals.
 - a) Special Edition MLN Matters Articles are numbered “SE”, followed by two digits representing the year it was published, followed by a sequential number distinct to the article. For example, *SE1418* would be the 18th Special Edition MLN Matters Article published in 2014.
 - b) Note: In addition to appearing on the MLN website, Special Edition MLN Matters Articles are listed on the transmittals website for the year they were published.
- a. Frequently Asked Questions – published on the CMS web site
- b. CMS maintains an FAQ website with questions and answers indexed by an FAQ number.
- c. Refer to the “Frequently Asked Questions Database” link under the “Medicare Related Sites – General” section on HCPro’s links page.

F. Other Guidance

- 1. CMS frequently posts other guidance on their web site in the form of documents or postings with important information.

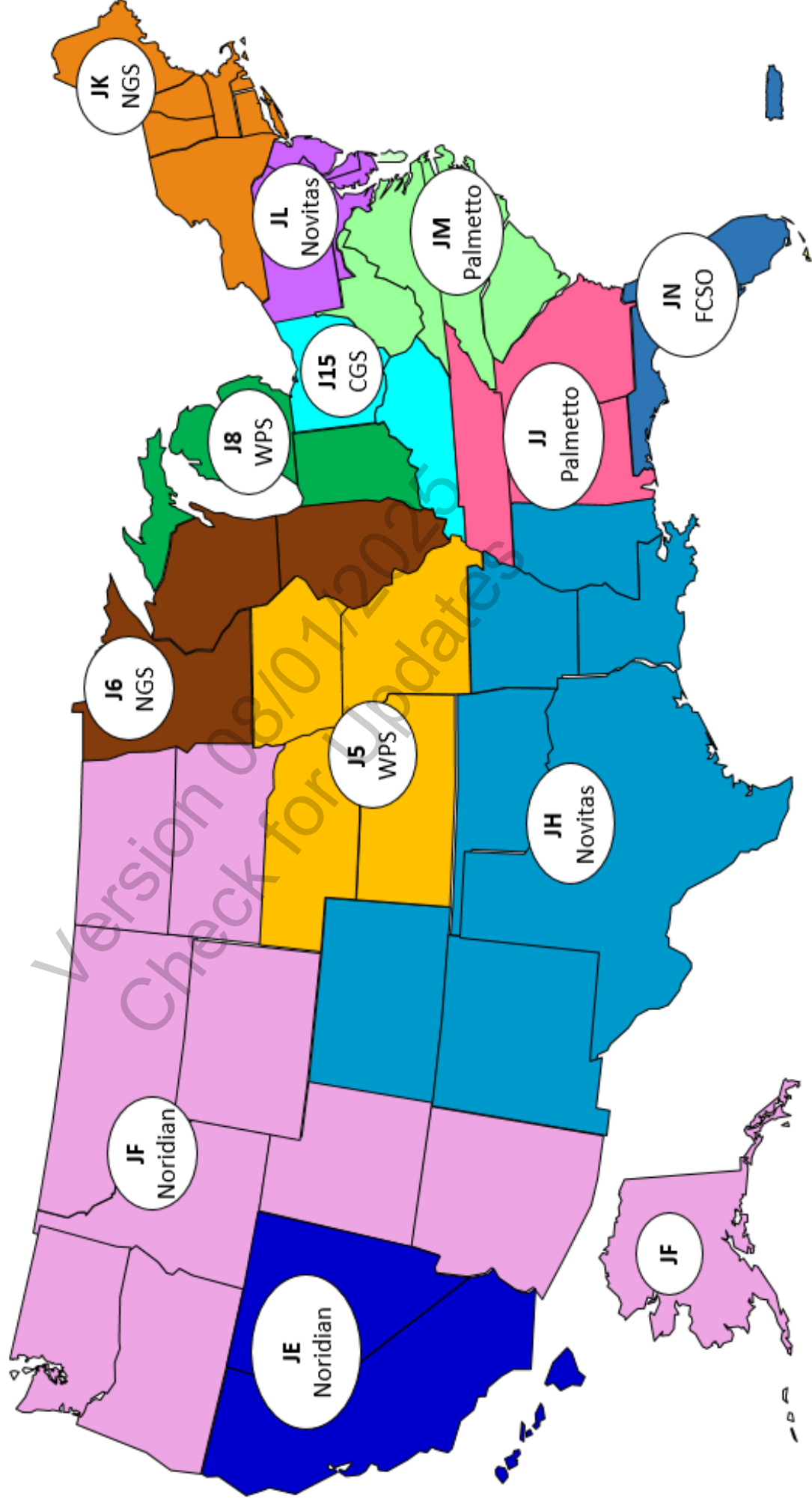
V. Ways to Stay Current (All Free)

- A. Review HCPro’s Medicare Insider for changes applicable to your facility.

1. Medicare Insider is a free publication, published weekly by HCPro. A link to sign up for the Medicare Insider, along with other helpful free publications, is included at the top of HCPro's links page ("Sign up for our FREE eNewsletters" next to an envelope in the upper left corner).
- B. Subscribe to CMS email updates. Sign up through the "CMS Email Update Lists – Subscriber's Main Page" link under the "Listserv Subscriptions" section on HCPro's links page.
 1. Suggested CMS mailing lists include:
 - a. CMS Coverage Email Updates
 - b. MLN Connects™ Provider eNews
 - c. Physician Open Door Forum
 - i. Note: CMS conducts periodic "Physician Open Door Forum" conference calls which provide very valuable information to physicians and physician group practices. You can receive dial in information by signing up to this list or checking the Physician Open Door Forum website.
- C. Refer to the "Open Door Forums – Overview Page" link under the "Medicare Related Sites – General" section on HCPro's links page.
- D. CMS News Releases (including proposed and final rule fact sheet)
- E. Subscribe to your MAC's email list.
 1. Included at the top of HCPro's links page ("Sign up for our FREE eNewsletters" next to an envelope in the upper left corner).

A/B MAC Jurisdictions

Posted 03/28/23



Medicare Administrative Contractors (MACs)-18

Posted 03/28/23

MAC Jurisdiction	Processes Part A & Part B Claims for the following states/territories:	MAC
DME A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	Noridian Healthcare Solutions, LLC
DME B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin	CGS Administrators, LLC
DME C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, Puerto Rico, U.S. Virgin Islands	CGS Administrators, LLC
DME D	Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands	Noridian Healthcare Solutions, LLC
5	Iowa, Kansas, Missouri, Nebraska	Wisconsin Physicians Service Government Health Administrators
6	Illinois, Minnesota, Wisconsin **HH + H for the following states: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, US Virgin Islands, Wisconsin and Washington	National Government Services, Inc.
8	Indiana, Michigan	Wisconsin Physicians Service Government Health Administrators
15	Kentucky, Ohio **HH + H for the following states: Delaware, District of Columbia, Colorado, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, and Wyoming	CGS Administrators, LLC
E	California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands	Noridian Healthcare Solutions, LLC
F	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	Noridian Healthcare Solutions, LLC
H	Arkansas, Colorado, New Mexico, Oklahoma, Texas, Louisiana, Mississippi	Novitas Solutions, Inc.
J	Alabama, Georgia, Tennessee	Palmetto GBA, LLC
K	Connecticut, New York, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont **HH + H for the following states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	National Government Services, Inc.
L	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania (includes Part B for counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia)	Novitas Solutions, Inc.
M	North Carolina, South Carolina, Virginia, West Virginia (excludes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia) **HH + H for the following states: Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas	Palmetto GBA, LLC
N	Florida, Puerto Rico, U.S. Virgin Islands	First Coast Service Options, Inc.

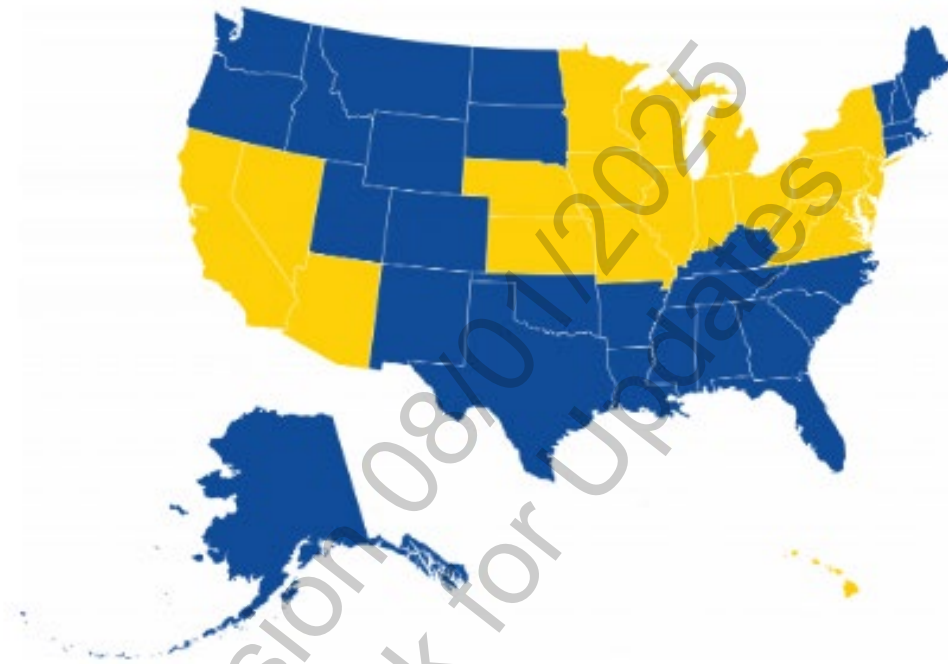
****Also Processes Home Health and Hospice claims**



<https://bfccsurveycenter.org/bfcc-qio-program/>

Locate Your QIO

The purpose of the BFCC-QIO Program is to improve health care services for Medicare beneficiaries through performing statutory review functions. CMS and the BFCC-QIOs ensure that care provided by the Medicare Program is medically necessary, reasonable, meets professionally recognized standards of care, is provided in the appropriate setting, and complies with certain standards under the Emergency Medical Treatment and Labor Act. Two BFCC-QIOs, Livanta and Kepro, serve all 50 states and three territories.



[Learn More About Livanta](#)

[Learn More About Kepro](#)

Note: Kepro has changed their name to Acentra

**Physician/Non-Physician Practitioner Additional Documentation Limits
(As of 02/14/2011)**

In response to feedback from the RACs, physicians and their associations, CMS has modified the physician/non-physician practitioner additional documentation request (ADR) limits for the RAC program.

1. The limits will be based on the servicing physician or non-physician practitioner's billing Tax Identification Number (TIN), as well as the first three positions of the ZIP code where that physician/non-physician practitioner is physically located. For example:

Physician Group ABC has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356. This group would qualify as a **single entity** for additional documentation limit purposes.

Physician Group XYZ has TIN 123456780 and is physically located in 12345 as well as 21345. This group would qualify as **two** unique entities for additional documentation purposes and each location would have its own additional documentation request limit.

2. ADR limits will be based on the number of individual rendering physicians/non-physician practitioners reported under each TIN/ZIP combination in the previous calendar year.

Group/Office Size	Maximum number of requests per 45 days
50 or more	50 records
25-49	40 records
6-24	25 records
Less than 5	10 records

Example 1: Group ABC has 65 physicians and non-physician practitioners that billed Medicare fee-for-service claims last year. The group's additional documentation request limit would be 50 additional documentation requests every 45 days.

Example 2: Group XYZ has 6 physicians and non-physician practitioners in their practice that billed Medicare fee-for-service claims last year, four are located at a clinic in ZIP 12345 and two are at a clinic in ZIP 21345. The maximum additional documentation limit would be 10 additional documentation requests every 45 days, per site.

The CMS reserves the right to give the RACs permission to exceed the cap. Permission to exceed the cap may be granted on CMS's own initiative or upon request by a RAC. Affected physicians/practices will be notified in writing.

At times it may be difficult for a RAC to accurately determine the size of a physician/practitioner group. If a request is received that does not adhere to the above guidelines, the practice should contact the RAC with documentation of the group size. If the number of full time equivalent physicians and non-physician practitioners is significantly different than the number of individual rendering physicians and non-physician practitioners appearing in the RAC's claim data, the group may petition the RAC for a modified limit. Groups may also work with the applicable RAC to establish a point of contact for the entire group, and/or a single mailing address for RAC correspondence. If additional assistance is needed please contact CMS at RAC@cms.hhs.gov.

Version 08/01/2025
Check for Updates