



THE BASICS

Paying the Bills: Medicare Administrative Contractors

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The Medicare fee-for-service program, the nation's largest health insurance plan, is administered by private organizations under contract to the Centers for Medicare & Medicaid Services (CMS).¹ Called Medicare administrative contractors (MACs), they enroll providers, educate them about coverage and appropriate billing, answer beneficiary and provider inquiries, and detect fraud and abuse. Their primary task, however, is prompt and accurate payment of the 1.2 billion claims submitted yearly for Medicare-covered services.

FROM CLAIMS TO PAYMENTS

Providers submit their claims, typically electronically, to the MAC that is responsible for their geographic area. The claims include information about the provider, the beneficiary, and the services the beneficiary received. The MAC reviews each claim with computerized algorithms called edits (or screens) that are designed to ensure that payments are made to certified providers for covered services delivered to eligible beneficiaries.

CMS-developed software is used to determine whether billed services are covered by Medicare. To be covered, the service must be in a statutorily defined category of benefits, such as physician services, and must be medically necessary, that is, "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."² Determining that a service is in a benefit category is generally straightforward; determining medical necessity may be more difficult and sometimes require manual review. Each MAC uses information gathered through provider inquiries or claims review to identify ambiguities or problems in determining "reasonable and necessary." It will then provide targeted education to providers to better define

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

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coverage requirements and may add local edits to the review software to ensure compliance.

Other computerized edits are applied to the claims, again using CMS software, to ensure that Medicare's billing policies are followed. Certain services, for example, are checked against utilization screens. If a provider delivers more units of a service than would typically be provided on a single day to a patient, the provider must justify the excess units. The edits also examine pairs of services delivered by a single provider to a patient on a single day to flag those that typically are not paid for separately. For example, the Medicare payment for an injection is included in the payment for an office visit, so any claim that listed both services for payment would not be allowed. Similarly, pairs of services that could not reasonably be performed together, such as two methods of repairing the same organ, would be identified through automated edits. A provider may need to give additional information or justify payment for any claim that was flagged with these edits. Patterns of billing problems could compel the MAC to augment the CMS software with additional local edits.

Provider information on the claim is checked against a CMS database to ensure it is complete and accurate and that the provider is Medicare-certified. The common working file (CWF), a CMS database of beneficiary information, is used to check for beneficiary eligibility and any actual or potential duplicate billing or conflicts between prior claims and the current claim.

After a claim passes through the edits, the MAC calculates the payment amount. Although most provider payments are based on national fee schedules or formulas, remittance to the provider depends on certain geographic adjustments, particular provider characteristics, and the beneficiary's copayment requirements.

COVERAGE AND PAYMENT FOR NEW SERVICES

Automated claims processing relies on Medicare billing codes, which uniquely identify each service and are associated with a Medicare fee. Until a new technology, device, or procedure is assigned a code and, through a separate process, a payment amount, a claim for the new service may need to be processed manually by the MAC. In some instances, clinical personnel at

the MAC may determine that the new service is similar enough to an established service that it can be covered and paid based on the established service. When there is no similar established service, the MAC will consult with other contractors and clinicians and will review medical literature and other evidence to determine coverage and an appropriate payment amount. As a result, coverage and the Medicare fee for a new service may differ across MAC regions until the service receives its own billing code and payment amount.³

AFTER PAYING THE BILLS

In addition to pre-payment review of Medicare claims, MACs routinely examine paid claims for indications of improper payments, again using automated systems. They periodically sample a small number of claims to check for evidence of improper coding, such as an incorrect billing code. MACs may request additional medical information from the provider to support these investigations. The MACs may also identify possible coding or coverage problems through provider complaints or questions. To better understand the extent and severity of a potential problem, the MAC may then select a targeted sample of claims for review. The MAC then develops an action plan to correct the situation.

If a MAC identifies systematic coding or coverage problems, it may develop more routine edits to incorporate into the pre-payment review or identify particular providers or services to target for additional, specific pre-payment review.⁴ Frequently, a MAC will develop a local coverage determination (LCD) to address a coding or coverage issue. LCDs specify the conditions under which a service will be paid, such as the number of times a particular service may be provided to a beneficiary, the diagnoses for which a particular service may be prescribed, or the settings in which a particular service may be delivered. An LCD is based on a review of medical literature and consultation with experts. After the review and comment period, the final LCD applies only to the beneficiaries and providers in the contractor's geographic region.

An important objective of post-payment review is to improve the pre-payment review process through additional computerized edits and to reduce provider errors so that fewer claims need to be reviewed manually. Although the number of claims that are

manually reviewed is not compiled, studies indicate that the vast majority of claims are processed and paid without manual intervention.⁵ Manual review raises the cost of claims processing and extends the time between submission and payment. Therefore, MACs must balance the costs of manual review with the risk that some inappropriate payments will slip through the automated reviews.

ENDNOTES

1. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to reform its contracting methods. To comply, CMS is shifting responsibility for claims processing to the new entities known as MACs from fiscal intermediaries and carriers. Fiscal intermediaries have had responsibility for claims from most institutional health care providers, such as hospitals and skilled nursing facilities, and carriers paid claims from professional providers like physicians. By 2011, when the process is complete, the 23 fiscal intermediaries and 17 carriers will be replaced by 23 MACs, which will process both institutional and provider claims. An additional 4 MACs will administer claims for durable medical equipment providers.
2. Social Security Act, Sec. 1862. [42 U.S.C. 1395y] (a) (1)(A).
3. For a description of Medicare's method for establishing the fee for a physician service, see "Relative Value Units (RVUs)," National Health Policy Forum, The Basics, February 12, 2009; available at www.nhpf.org/library/details.cfm/2720.
4. The MAC's claims review activities are designed to identify and prevent improper payments, that is, claims paid that should not have been paid because the services were not covered or there was not adequate documentation to justify the claim. Sometimes improper payments may indicate fraud or illegal activities. If the MAC uncovers potential fraud through its review process, it will notify appropriate law enforcement or Medicare's specialized contractors that are tasked with correcting past improper payments and preventing fraud.
5. The General Accounting Office (GAO) estimated in 2001 that at least 90 percent of physician practices had no claims subject to review; one-tenth of 1 percent of practices had 30 to 50 claims selected for post-payment review. GAO, "Medicare: Recent CMS Reforms Address Carrier Scrutiny of Physicians' Claims for Payment," GAO-02-693, May 2002; available at www.gao.gov/new.items/d02693.pdf. Medicare's Comprehensive Error Rate Testing (CERT) contractor samples about 130,000 claims from physicians, practitioners, and suppliers and almost 40,000 hospital claims to determine whether they had been paid in compliance with Medicare coverage, coding, and billing rules. CMS, "Improper Medicare Fee-for-Service Payments Report," May 2008; available at www.cms.hhs.gov/apps/er_report/preview_er_report.asp?from=public&which=long&reportID=9.

*Prepared by Laura A. Dummit.
Please direct questions to ladummit@gwu.edu.*