Do You Know Your Medicare Fee-for-Service Contractors?

There's a virtual alphabet soup of Medicare contractors out there – all serving the agency in very different roles and during different times in the billing process. In fact, many providers think they are dealing with a Recovery Audit Contactor (RAC), when they are actually working with a Medicare Administrative Contractor (MAC) or a Supplemental Medical Review Contractor (SMRC). **Let's review the current Medicare contractors and what roles they play.**

Recovery Audit Contractor (RAC)

- Audits post-payment Medicare Fee-For-Service (FFS) claims to ensure the claims were billed according to Medicare policy
- Very limited claim review:
  - Only reviews 26 audit issue areas approved by CMS (down from 800 issue areas in previous years)
  - Limited to reviewing just 0.5% of a provider's claims (within the 26 issue areas) for billing errors
- High rate of accuracy (95%) per an independent contractor
- The only Medicare contractor that pays providers in Regions 1-4 for records requested, even electronic records

Supplemental Medical Review Contractor (SMRC)

- Investigates OIG and GAO report findings
- Evaluates medical records for compliance with coverage, coding and billing practices.
- No limit on document requests

Unified Program Integrity Contractor (UPIC)

- Performs investigations specific to suspected instances of Medicare and Medicaid billing fraud and/or abuse
- UPICs replace the Medicaid Integrity Contractors (MIC), The Zone Program Integrity Contractor (ZPIC) and The Program Safeguard Contractor (PSC)
- The only contractor that meets with providers on-site

Comprehensive Error Rate Testing (CERT)

- Idientifies and estimates the rate of imporper payments in Medicare
- Publishes an annual Medicare CERT error rate report

Medicare Administrative Contractor (MAC)

- Enrolls a provider in the Medicare FFS program
- Processes Medicare FFS claim payments
- Handles provider reimbursement services
- Provides education for providers regarding billing requirements and responds to providers' questions
- Reviews provider claims pre-payment and post-payment for billing accuracy
- No limit to the number of records they can request from a provider
- Establishes local coverage determinations (LCDs)
- Handles the first level of the appeals process

Quality Improvement Organization (QIO)

- Improves the quality of care provided by the Medicare program
- Assists Medicare providers with improvement and reviews quality concerns of claims
- Ensures that Medicare only pays for services and goods that are necessary and most appropriate
- Addresses beneficiary complaints and conducts quality care reviews
- Conducts limited review of Part A inpatient claims

To learn more visit: medicareintegrity.org