MAC Who?

MEDICARE REPLACES FISCAL INTERMEDIARIES AND CARRIERS

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In our industry, the one thing that we can count on is that there will always be change. One of the major changes currently underway is the implementation of Medicare Administrative Contractors (MACs). This article will discuss the formation and status of the MAC award process as well as the potential operational impact on billing companies. While this column is dedicated to coding issues and concerns, I would argue that the impact of the implementation of MACs could have a significant impact on coding, especially for hospital-based physicians.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) paved the way for the Centers for Medicare & Medicaid Services (CMS) to make significant changes to the administrative structure of Medicare fee-for-service program. CMS reports that the goal of these changes is to make payor contracting "dynamic, competitive, and performance-based." The key element of the reform is the integration of the Medicare Part A (fiscal intermediaries) and Part B (carriers) into new entities called Medicare Administrative Contractors (MACs).

This integration will occur through a competitive bidding process, so that only one payor will be awarded the contracting services for both the hospital and the physicians in a designated region. The terms "fiscal intermediary" and "carrier" will become obsolete and will be replaced with the general term Medicare Administrative Contractor (MAC).

Selection of MACs

Fifteen (15) regions, organized by state, have been designated by CMS and each region will have its own MAC. The bidding and award process began in 2005; completion of the process is anticipated for 2009. It is CMS's goal that this openly competitive process will generate greater payor efficiencies for patients as well as providers. For example, patients should receive fewer EOBs, since only one payor will be billed by both the hospital and the physician.

As of the writing of this article, the current status of the MAC contract awards is as follows:

Status of MAC Contract Awards as reported on the CMS website, www.cms.hhs.gov/MedicareContractingReform/Downloads/PrimaryABMACJurisdictionFactSheets.pdf

Region	States	RFP Issued	RFP Awarded	Awarded Contractor
1	CA, HI, NV	12/15/2006	10/25/2007	Palmetto GBA
2	AK, ID, OR, WA	12/15/2006	Sept 2007	Not Announced
3	AZ, MT, ND, SD, UT, WY	9/15/2005	7/31/2006	Noridian
4	CO, NM, TX, OK	9/29/2006	8/03/2007	Trailblazers
5	IA, KS, NE, KS	9/29/2006	9/04/2007	Wisconsin Phy HIC
6	IL, WI, MN	Sept 2007	July 2008	TBD
7	MS, AK, LA	12/15/2006	Sept 2007	Not Announced
8	IN, MI	Dec 2007	Sept 2008	TBD
9	FL	Dec 2007	Sept 2008	TBD
10	AL, GA, TN	Dec 2007	Sept 2008	TBD
11	NC, SC, VA, WV	Sept 2007	July 2008	TBD
12	DE, DC, MD, NJ, PA	9/29/2006	10/24/2007	Highmark
13	NY, CT	12/15/2006	Sept 2007	Not Announced
14	ME, VT, NH, MA, RI	Sept 2007	July 2008	TBD
15	KY, OH	Sept 2007	July 2008	TBD

When selecting a regional MAC, CMS has stated that it will focus on "three critical areas: customer service, operational excellence, and financial management. The MACs will serve as the providers' primary point-of-contact for enrollment; training on Medicare coverage and billing requirements; and the receipt, processing, and payment of Medicare fee-for-service claims within their respective jurisdictions. These contractors will perform all core claims processing operations for both Part A and Part B. In their capacity as the face of Medicare to the providers, practitioners, and suppliers, CMS has stated that MACs will need to maintain a staff of experts knowledgeable in all aspects of the fee-for-service program" (according to the website www.cms.hhs.gov/MedicareContractingReform/Downloads/MAC_Jurisdiction_Facts.pdf). CMS has clearly defined expectations as to what the new MACs are to do for the healthcare community.

Impact on billing companies

The question that remains for us is how will the new MAC impact billing companies? Besides the obvious implication that many organizations will now be billing a new Medicare payor, one of the key issues is that the Medicare payor will now be able to match hospital and physician claim data. This is not a real concern for inpatient claims, since DRGs will continue to be used to reimburse hospitals. However, this is a major concern for outpatient services, especially radiology. What will *(continued on page 23)*

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happen when the claim data does not match? How will the payor respond? Which one is correct—the physician?—the hospital? Maybe neither. While I would argue that physician coding has the greater chance of being correct, since the codes are usually assigned by designated personnel, an across-the-board assumption of accuracy cannot be made. Given the continued focus on healthcare fraud and errors, MACs are a logical tool that the government can employ to identify new areas of audit focus.

As a billing company, you function on behalf of your physicians. If you bill for hospital-based physicians, it is important that you re-examine your (and/or your physicians') relationship with your corresponding facilities. Do they have a good charge capture processes? When your physician or your staff is aware that the hospital is charging incorrectly, do you have an effective line of communication back to the facility so that the charges can be corrected? Historically many hospitals and physicians have not been concerned about what the other is coding for performed procedures. That is a luxury we can no longer afford.

Hospitals and physician groups must coordinate to ensure that accurate claims are submitted for both entities. The absence of this coordination could result in unnecessary and troublesome payor audits, decreased cash flow as a result of pended claims, and many other scenarios, depending upon how payors choose to address coding inconsistencies between the professional and technical components. Don't be caught unaware – understand the implications, educate yourself, and be proactive in leading the way for change. Better to be an agent of painful change than to be left holding a negative report that you have to justify to your clients. ▲

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Summary of References:

CMS website with all information on MACs and Medicare Contracting Reform: www.cms.hhs.gov/MedicareContractingReform

CMS Information on the selection process for MACs: www.cms.hhs.gov/MedicareContractingReform/Downloads/PrimaryABMACJurisdictionFactSheets.pdf

CMS information on individual regions and status: www.cms.hhs.gov/MedicareContractingReform/Downloads/MAC_Jurisdiction_Facts.pdf