Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicaid Integrity Provider Audit Program

Wednesday, July 15, 2009

1:00PM – 2:30PM ET

Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss the Medicaid Integrity Program (MIP) provider audit program. This primary audience for this Special ODF is provider groups. Section 1936 of the Social Security Act requires CMS to enter into contracts to perform four key Medicaid program integrity activities:

1. Review of provider actions to determine whether fraud, waste, or abuse occurred or may have occurred;
2. Audit provider claims;
3. Identify overpayments; and
4. Educate State or local employees involved in Medicaid administration, providers, managed care entities, beneficiaries and others with respect to payment integrity and quality of care.

CMS has awarded umbrella contracts with several contractors to perform these functions. These firms are known as the Medicaid Integrity Contractors (MICs). There are three types of MICs: Review MICs, Audit MICs, and Education MICs. The Review MICs use advanced data mining and analysis techniques to identify provider targets for the Audit MICs to pursue. The Audit MICs conduct audits of these Medicaid providers and identify overpayments. The Education MICs provide education to Medicaid providers and others with respect to Medicaid payment integrity and quality of care issues.

During this ODF, CMS staff will discuss the:

- The MIP audit process;
- Audit timelines;
- Web site information;
- Future meetings/calls.

Afterwards, there will be an opportunity for the public to ask questions.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935

Reference Conference ID#: 17763217

Note: TTY Communications Relay Services are available for the Hearing Impaired.

For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will A Relay Communications Assistant will help.

An audio recording and transcript of this Special Open Door Forum will be posted to the Special Open Door Forum website: http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning July 24, 2009 and will be available for 30days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.hhs.gov/opendoorforums/ .

Thank you for your interest in CMS Open Door Forums.

Audio file for this Transcript:

http://media.cms.hhs.gov/audio/Mediciad_Integrity_Provider_Audits.mp3

Centers For Medicare & Medicaid Services
Special Open Door Forum:
Medicaid Integrity Provider Audit Program
Moderator: Natalie Highsmith
July 15, 2009
1:00 pm ET

Operator: Good afternoon. My name is (Teresa) and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on Medicaid Integrity Provider Audit program.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks there will be a question and answer session. If you would like to ask a question during this time simply press star then number 1 on your telephone keypad. If you would like to withdraw your question press the pound key.

Thank you. Ms. Natalie Highsmith you may begin your conference.

Natalie Highsmith: Good afternoon and good morning everyone and thank you for joining us for this Special Open Door Forum on Medicaid Integrity Provider Audit Program.

The primary audience for today's open door is provider groups. Section 1936 of the Social Security Act requires CMS to enter into contract to perform four key Medicaid Program Integrity activities: review of provider actions to determine whether fraud or abuse has occurred or may have occurred, audit provider claims, identify overpayments, and educate state or local employees

involved in Medicaid administration and others with respect to payment integrity and quality of care.

During this Special Open Door CMS staff will discuss the Medicaid Integrity Program audit process, audit timelines, website information, and discuss any future meetings or calls. Afterwards there will also be a chance for you to ask questions.

I will now the call over to Mr. Paul Miner who is the Deputy Director of the Medicaid Integrity Group.

Paul?

Paul Miner: Welcome everybody. It's been a while in putting this together and I hope we all come away from this process knowing a little bit more about the national Medicaid provider audit program.

And let me state very simply the purpose of this Open Door Forum today is twofold really. One is to provide you with an update of the Provider Audit Program, tell you what we've done, where we've been, where we're going. But more importantly it's to provide a forum to you to address issues, concerns, et cetera that many of you have expressed over the past several months.

But another point that's very important is it's an opportunity for us basically to listen to you - to get a better understanding of your day to day problems, concerns, issues, and so forth. And I think this will help inform how we continue to build and shape this national provider audit program if we're mindful of the issues that you face on a day to day basis.

Let me say a word quickly about outreach in general. I have an admission to make to you. I mean we - the Medicaid Integrity Group is three years old this month. And obviously Medicaid Integrity Group was created here at CMS to implement the Medicaid Integrity Program that you're familiar with that Congressed passed as part of the Deficit Reduction Act.

The admission is this - we have largely been engaged over the past three years in basically building an organization and building the infrastructure necessary to get an organization up and running. There are many large organizations I'm sure but this is not an insubstantial one. And an awful lot of time and effort goes into that.

At the same time we've been spending an awful lot of time trying to develop a fair and consistent provider audit program. The fact of the matter is this, we can do a better job of provider outreach.

And we are currently doing a number of things and this Open Door Forum is frankly the first in a - I would say a series of different sorts of efforts to reach out to the provider community. So helpfully this Open Door Forum will be of use to you.

A couple of other things that we've been doing. We're in the process of pushing out FAQs - some seven or eight pages worth of frequently asked questions - questions I think that are important to all of you we will issue shortly along with the FAQs a number of documents.

One is a procurement timeline so you have a better sense of when contractors are coming online and so forth. We've been asked to provide a little more background as well in terms of the program and its goals and what we open to achieve and how we intend to work with all of you.

And also another document that we think would be very, very useful that we call audits A to Z. And once these documents have been cleared through the CMS process we will push them out in a verity of ways and we will post them on our website which I would like to - for some of you that may not know that website let me give it to you now. And it's www.cms.hhs.gov/medicaidintegrityprogram .

Another thing that we're doing in terms of outreach that I think is very important and I think Congress recognized the importance of this as well. And that is awarding contracts - two contracts in particular in September dedicated primarily to provider education.

So we're hoping a combination of these things - more efforts of this sort will hopefully serve you well and it will serve us well too.

Talk a little bit about today and how we're - how we tried to structure the approach had the agenda to this open door forum. We've tried to do it in a way that maximizes flow of information and addresses your issues and concerns to the maximum extent possible.

Each Medicaid Integrity Group, or MIG, Division Director will give you a brief update of what they've done, what they're doing in their respective areas, and we focus specifically on areas that we think are of most interest and important to you. And we're going to start with data issues. We will move to audit related processes and the kinds of coordination that we need to do or that we can do better and so forth. And finally we'll talk to contractor procurement activities and timelines.

I think you'll see that sort of you -- in the course of the presentations by our division (unintelligible) -- I think you'll see that some of your questions,

concerns, issues, either have been or are in the process of being addressed currently.

And if we can get that information out to you that way I think we can focus on those things that still need to be dealt with, that still need to be discussed, and not waste a whole lot of time on issues that are essentially dealt with.

So that's our idea on how to structure this and we hope it works very well.

We will then open the floor for questions after that. One last thing though that I think I should say. It's entirely possible in the time allotted to us that you may not be able to get all the questions in that you hoped to or perhaps after the session is over another thought - question, whatever may occur to you.

And if you're unable to get those questions raised here at the open door forum or think of something later on you can send those via email to us to our corporate mailbox which is Medicaid underscore Integrity underscore Program at cms.hhs.gov.

So with that as background and hopefully kind of framing the process why don't we get started. And let me turn it over to Jim Gorman and Jim is the Director of our Division of Fraud, Research and Detection which is basically our in house research and data division.

Jim?

Jim Gorman: Okay well thanks Paul. Let me give you a brief overview of where we are with respect to data and the reason it's important to us and where we're going. And I'll also talk a bit about what we have, what we don't have, and what we have that's right and what we have that we don't think may be right.

And what we have are - is a subset of the Medicaid data (unintelligible) program. You submit a claim, they capture it, they adjudicate it, you get some money sometimes, and we get a copy of that. But we only get a copy of certain fields within each claim.

But we have been getting at CMS for years for research purposes we looked at it, we piloted it with a number of states and we determined at least to some extent it was contemporary enough and accurate enough to begin our program while we went off and identified what was missing that would make it a complete data set absent getting all of the data from the program - the state programs.

We've loaded that data on a database in California. We have started an analysis of that data and we've gone through about half of the state. We've identified a large number of suspect overpayments and we commenced audits in many of the states and again we're approaching half of the country. By the end of the calendar year we will be in the entire United States.

We're talking with states about the submission of a more complete set of data so we can do a more thorough audit. Let me give you an example. We only get - by the way that provider ID. That's all we know when we data mine. We know an ID number, a Medicaid ID number. That's the only information we have.

Therefore if nothing else our electronic audits are unbiased and they're comprehensive with respect to everybody gets the same look for whatever query we happen to be making at that time.

We look first at rules based kinds of things. Is this an allowable service? Was it service provided in conjunction with another service perhaps it's a part of the panel in the case of a lab that was unbundled.

We have hundreds of those types of queries or algorithms that we run against the data. We amass the results. We indentify the providers who seem egregious to the point that we should do something about a recovery effort or at least a second look or perhaps a billing problem or perhaps it's a data problem.

For example in one instance in one state we had identified a large number of payments - duplicate claim payments. It turns out that that state for that period of time - it was a year - had not sent any of their adjustment information in.

And so those are the kinds of issues that we're running into more than the data is not good or the data is corrupt in some fashion. It actually seems to be pretty good. It's just sometimes not as complete as we'd like it to be and it's not as contemporary as we'd like it to be. It's at least three months old before we get to see it.

So, based on that, we put that data together with other information such as a drug file for pricing, maybe Medicaid eligibility files for checks of payer of last resort. We have a country's debt master file - the social security debt master file that we're loading. All of these are also residents in the database and are checked with when we view claims information for validation and accuracy.

That in a nutshell is it. The outcome is as I think we've said we've got audits going on to the extent about 500 now. We have other initiatives where we think it's sort of a binary situation where this can't be provided if you get that or this is an impossible service to be provided - an impossible amount of a drug for example to be spent.

So we think there's an Robb Miller or there. Those kinds of things we're going directly to the states with and we're just saying unless your data is wrong and please take a look then these are billing Rob Miller or is that just need to be corrected and adjusted.

And we're working with them on doing that and we have had, you know, we have reason to believe that again the data has been good enough for us to go to that level of detail.

So that's where it is with respect to the data today. We have a major initiative as I said and to get the rest of that data along with other entities in CMS. Also we're asking states (unintelligible) for comprehensive data set for all the various purposes here.

And I think that that's probably something like a year to two years away before we can see the necessary administrative work and build the infrastructure to have that occur. But we're working on it it's one of the priorities here. And that - at that time we'll have as good of data as they have on site at the states to do our function.

I think any time that you run into issues with providers that - with react to data we want to know about it so we can correct and adjust (unintelligible).

And that in a nutshell is where we are.

Paul Miner: Okay Robb (unintelligible).

Robb Miller: Good afternoon everybody. My name is Robb Miller. I'm the Director of Field Operations for the Medicaid Integrity Group. And my organization within the overall group has kind of the primary responsibility for screening potential provider audits that will be conducted out of the states.

And I want to talk a little bit about how that process takes place and also some of the things we're doing to try to coordinate our activities in a way that creates as few impediments as possible for everybody.

We call the process vetting. The - we made a kind of commitment early on that we would work as closely as we can with states and our law enforcement partners to make sure that we are not duplicating the work that they're already doing out in the field.

And the meaning for that for you is that if a state is reviewing a provider that's on this call today for the same reason that we may develop a potential cause for an audit then we stand down.

And so on a monthly basis when Jim's folks send us a list of potential auditees we work with the states to make sure that those providers are not already under review for the same reasons.

We also work with law enforcement which includes the Office of Inspector General, the Department of Justice, and the Medicaid Fraud Control Unit within each state similarly to make sure that we're not stepping on any criminal or civil investigation that may be taking place. We also check with the Medicare contractors in those respective jurisdictions as well.

Assuming that screening process is uneventful then we pass that list back to our Medicaid Integrity Contactors or MICs and Barbara Rufo will talk to you about, you know, geographically which MICs work in what area.

And then that would begin the process from which an audit would emanate. You know, Jim talked about the binary type of reviews - the sort of if this, not that.

The typical - the more typical audit that you are probably more directly faced with is kind of a standard audit where one of our contractors will contact you and ask for records, review those records, et cetera.

We currently - as Jim said, you know, we've got - we're screening data for over half the country any we'll have - we'll be actively screening data in the whole country by the end of the year.

As of the most recent report we have from our contractors we basically are actively conducting audits in 17 states today. And there's slightly fewer than 500 of those audits that are active.

In terms of provider type, 44% of those audits are being conducted on hospitals, 29% on long term care facilities, 21% on pharmacies, and then all the rest of the provider types - transportation, (unintelligible), lab, et cetera, comprise the remaining 6%. So those are the audits that are actually going on out there now,

I want to talk briefly as well about what you can expect when an audit is conducted. The contractors that have the responsibility for conducting the audits are required to follow the generally accepted governmental auditing standards or GAGAS - also known as the yellow book standard.

And they do have protocols that they use as guidelines. They are expected to exercise their best judgment - their best professional judgment. They are independent contractors. They have the ability and expertise to conduct these audits. And they will be reaching out to you, notifying you of the commencement of the audit asking you for records.

Once the records have been examined and the preliminary conclusion is reached the contractor gives back to CMS the draft audit reports. We review that and once it passes our examination then the contractor will - sorry then we will send it to the state Medicaid agency in which the audit was conducted.

And the purpose of that is to make sure that we are correctly interpreting the state's policy, practices, procedures. Because you all know as well as we do every state is very different even though it's the same Medicaid program. We want - and our contractors are required in advance to even being operational to work with the state Medicaid agency to make sure that they understand all their current policies and procedures.

But we want to make sure in every case that we're not misinterpreting anything. So the state gets a look at the draft audit report, they make comments, they make revisions as necessary. And the contractor will send you the provider the draft audit report.

Typically you'd have 30 calendar days to review that report, provide whatever other supporting documentation you might feel is appropriate to mitigate the findings, and again whatever revisions are appropriate will be made.

We CMS will review the revised draft audit report and we'll share the second time with the state to make sure again that we are correctly interpreting all the rules as it relates to the issue that is being examined. This obviously makes sense. It's only fair to you. It's only fair to us and the state.

When the issue is finally resolved then we will issue a final report to the state. The state then has the responsibility to recover whatever overpayments may exist. And whatever procedures take place in the state in which you operate - whichever state that is - that is the administrative process that will be followed. That state will notify you of the final finding. That state will initiate

whatever action is necessary. Our contractor will be there to support the state's activities, answer questions, provider work papers, testify even at hearings if necessary.

But that resolution - the final resolution of the audit takes place at the state level because the state is the one that actually has a direct legal relationship with you. So that's just a snapshot of how that process is going to take place.

One of the things that we hear, you know, in our various conversations are, you know, comparisons and contrasting with the recovery audit contractors which is obviously another CMS initiative with which most of you are familiar.

And they are some similarities and they're also obviously some differences, the main one being in Medicaid there's two sets of partners who manage the program. You know, on a day in and day out basis the state has a lot of say in terms of how the Medicaid program is managed whereas CMS directly administers the Medicare program.

But we had been talking a lot with the - every audit contractor to find areas where we can work together to make sure that we - that there are processes that you understand and that cause you as little grief as possible without taking anything away from the integrity of the audit itself.

There's a few areas that I think this is particularly relevant and that we hear from folks on. You know, one is that the RACs tend to - they just look back I believe three years at this most. And while we have the ability and the legal authority to look back basically as far as records may exist what we have adopted is a policy as a general rule that in whatever state the audit is being conducted we would mirror that look back period that the state typically uses.

So if you're in state X and the state Medicaid agency typically looks back three years then we typically would look back three years. That's subject to change and if there's, you know, reason to extend that or for that matter to reduce that look back period then that's certainly very possible.

The number of days required to produce the records is another area that we hear in terms of comparing this to the recovery audit contractors. The - I think the RACs typically allow 45 calendar days plus an extension if the request is submitted within that 45 day period.

And while we initially had had a much tighter timeframe we have begun examining longer timeframes. Again we're giving strong consideration to mirroring whatever the process is and the practice in the state in which you operate.

So if, you know, Illinois for example typically allows 30 business days then we would allow at least 30 business days. I think we've also heard loud and clear from hospitals in particular where there tends to be the, you know, as you noted the large plurality of our audit so far - 44% of them are in hospitals and they tend to have a larger number of records that are under question.

We've heard from hospitals that pulling the records sometimes can be a little challenging because as Jim was talking about the data set that we have doesn't have a couple of key fields hat may be really relevant for hospitals. And that's the medical record number and the account number.

So hospitals kind of have to find another way to work around pulling those records. And, you know, and may need that full 45 days for example the RAC provides. We're having discussions internally about trying to formalize something more along those lines.

You know, and just speaking along that area, you know, one of the questions that we get from pharmacies is, you know, we need the prescription number to be able to pull the record. And unfortunately in the current state of the data we don't have the prescription number. But there are other ways to pull those records and we will be happy to work with, you know, individual providers if you're having any problems along those lines.

And then finally the number of records is another area where there's comparison. For example in the RAC FAQs the maximum number of records for PPS hospital for example is 200 per NPI per 45 day period. We do not have anything along those lines but we are cognizant that, you know, we don't want to make massive record requests, you know, unless it obviously makes a lot of sense.

So we have spoken with our contractors. If in fact there are hundreds or more records to be requested, you know, that it may be wise to use an informal sampling or a probe sample early on to make sure that we're, you know, that we're on track before we ask a provider to produce 4 or 500 records.

And once that informal sampling is conducted then we can make a decision going forward. It may be that it's not necessary to ask for anymore. We may, you know, may feel that well, you known, these were - showed up (unintelligible) everything else and maybe we just talk to you about showing us, you know, why the others aren't inappropriate.

It could also be that we could do more formal sampling and possibly even extrapolate the findings depending on what the state's administrative procedures in that respect are as well.

And then finally in terms of RAC coordination one of the things that we've talked to the folks in CMS that oversee the recovery audit contractors are

trying to make sure that we stagger the audits so to speak and we are trying to see if that's possible.

So in other words if a RAC audit is going on in a hospital in Georgia today, that the next day, the first thing they get in the mail is a notice from a MIC Contractor saying we're going to start an audit tomorrow. We recognize that these can be burdensome. We recognize of course they're important and necessary and legally required, but we do want to try to minimize the impact. And I think that we'll probably be able to work something out along those lines.

You know, one of the big differences between our contractors and RACs (unintelligible) that it's something I should highlight and that is that RACs by law, are contingency-based. In other words, the more overpayments that they identify on a recovered, the higher their compensation is.

Medicaid Integrity Contractors are more what I would call a fee-for-service based system. They provide a service. They get paid. They are eligible for rewards or bonuses, as it were, depending on how efficient and effective they are. But in no circumstance is the dollars identified or recovered tied to compensation for MICs. So I know that's an issue that, you know, some folks have some concerns about.

So I think that those are the kind of the main things I wanted to highlight about our processes, in that respect and I'll turn it back over to Paul.

Paul Miner: Thank you, Robb. And finally, Barbara Rufo is the Director of the Medicaid Integrity Contracting Division here. Obviously you can tell by the title of the division, it is our in-house contracting function and Barbara will fill you in, in terms of procurement status with MICs.

Barbara Rufo: Thank you, Paul. As Paul indicated, I'm going to give you a high level summary of where we are procurement wise. To date, we have three types of umbrella contracts awarded.

And let me explain an umbrella contract. Basically, an umbrella contract allows us to run a competition amongst a pool of vendors within the statement of work that we solicited previously. And it allows us to basically identify which contractor within a particular region will perform the work within the statement of work that's outlined.

The three umbrella contract types that we have, we have a Review of Provider MIC. We have an Audit MIC and we have an Education MIC. The Review of Provider MIC basically works with Jim Gorman's division, Division of Fraud Research and Detection, to analyze the data and identify potential leads for prospective audits.

The pool of vendors that we have, we (thought) we've identified five review MICs. They are Thomson Reuters, AdvancedMed Corporation, ACF Healthcare Analysts -- Analytics, IMS Government Solutions and Safeguard Services.

The Audit MICs they basically help Division of Fraud - or I'm sorry Division of Field Operations, Rob Miller's group, when they conduct the audits. They go on-site or they'll do desk audits, depending on what is identified. And they'll actually audit the records of the providers.

The pool of vendors we have there, we again have five vendors. We have Booz Allen Hamilton, Health Management Systems, Fox & Associates, Health Integrity and IPRO.

The third umbrella - or the third set of umbrella contractors, if you will, we have education MICs. We have two vendors that currently hold umbrella contracts that's (Information Experts) and Strategic Health Solutions.

Basically what CMS does in order to identify which contractors will represent CMS in the different regions; we'll run a competition amongst those umbrella holders. We've currently held numerous competitions for the Review of Provider MICs. We have identified six regions to date and we have (contractor oversight).

The regions that we currently have contractors in, we have the Philadelphia and Atlanta region for the Review of provider MIC and that is Thomson and Reuters. We have the Dallas and Denver region, as well as Chicago and Kansas City, that's AdvancedMed.

We have two competitions that we're currently running for the Review of Provider MIC and that is the San Francisco and the Seattle region and then also the Boston and New York regions. The Boston and New York region should be awarded some time next month. And the San Francisco/Seattle region should be awarded by September of '09.

If I move on to the Audit MIC task orders. The regions that we have awarded so far, we have the Philadelphia/Atlanta region and that was awarded to Booz Allen Hamilton. We have Dallas/Denver region, which was awarded to HMS. We have the San Francisco/Seattle region again with HMS.

And then we're currently in the process of running two additional competitions. One is with the Boston/New York region and that competition should be awarded within the next week. We're hoping to be able to make that announcement. And then, the Chicago/Kansas City region, that should be awarded by September of '09.

For the most part, let me explain a little bit about the Audit MICs. As Robb had indicated that they're going to go out and conduct audits. And that's basically their prime responsibility. So the Review of Provider MIC will identify potential leads. CMS will evaluate those leads, as Robb indicated, we will RAC the leads with the (unintelligible) our partners, if you will, and then we will furnish those leads over to the audit MIC.

The audit MIC then goes either on site, desk audit, whatever the type of audit to be conducted. And they'll actually perform the audit and they'll coordinate with CMS on the audit findings.

Upon completion of the audit, we may find that there are areas, you know, that could be of concern where we might need to educate providers. And that's what our Education MICs do. We awarded, as I indicated, we awarded two umbrella contracts, one to (Information Expert), one to Strategic Health Solutions. We are actually in the process, as I speak, in conducting the competitions on those two types of education task orders.

The first task order, we're conducting a GAP analysis of existing education and training efforts. And we're going to look at what the Education MIC identifies for potential areas and then we will coordinate with our partners and we will identify those training needs to the Education MIC.

And then the second education task order that we're looking at. We're developing a web based training mechanism. And that is basically for pharmacy type healthcare efforts. So with that said, you know, all our contracts should be awarded by September of '09, which will complete the jurisdictions that we've identified. And there will be (presence) nationwide in all the review of provider, the Audit MIC and the education task order.

Paul Miner: Okay. Thank you, Barbara. And with that, hopefully that kind of lays out and frames for you what we've done and what we're doing and may possibly even have answered a few questions that you might have had. But I have a feeling you have a lot of questions anyway. So let's - operator, let's open up the floor for questions.

Operator: Yes...

Natalie Highsmith: I'm sorry. Theresa, if you can just remind everyone on how to get into the queue to ask their question. Everyone, please remember when it is your turn, to restate your name, what state you are calling from and what provider or organization you are representing today. And also, we have close to, if not over, 1000 participants on the phone line. So we are asking that you have one question and one follow up question. And if you have any further questions, you can get back into the queue to ask your question or just submit your question to the medicaid_integrity_programs@cms.hhs.gov email. Theresa?

Operator: At this time, I would like to remind everyone if you would like to ask a question, please press star then the Number 1 on your telephone keypad. We will pause for just a moment to compile the Q&A roster. Your first question comes from the line of Peter Hughes from New Jersey.

Peter Hughes: Hi. I'm wondering if you could run through the timeline for the implementation again, for the benefit of all us? Thank you.

Robb Miller: Well, I'm just going to suggest that I think that will be out on our Web site relatively soon, but you know, we could touch on the high levels.

Paul Miner: Okay.

((Crosstalk))

Barbara Rufo: Okay. The Review of Provider MIC for regions, what we considered 5 and 7, which is Chicago/Kansas City region. That was awarded to AdvancedMed. Regions 6 and 8, the Dallas/Denver region was awarded to AdvancedMed as well. Regions 3 and 4, Philadelphia/Atlanta regions, was awarded to Thomson and Reuters. The two regions left to be awarded, regions 9 and 10, which is San Francisco and Seattle, will be awarded in September of '09. And regions 1 and 2, Boston/New York will be awarded July. I expect that to be awarded within the next couple of days. And that's for the Review of Provider.

For the Audit MICs, the regions left to be awarded, Boston/New York region, should be awarded this month and the Chicago/Kansas City region should be awarded by September. The regions for Philadelphia/Atlanta, was already awarded to Booz Allen Hamilton. Dallas/Denver region was awarded to HMS. San Francisco/Seattle was awarded to HMS. And then the two education MICs, they should be awarded by September.

Jim Gorman: So I think, this is Jim Gorman. I think the expectation then is by the end of this calendar year, we will be operational in each state in the country.

Paul Miner: Correct. That is correct.

Operator: Your next question comes from the line of Joel Vaneaton from Tennessee.

Joel Vaneaton: Thank you. This is Joel Vaneaton with Care Centers Management Consulting in Johnson City, Tennessee. Just a question, as to - I represent field nursing facilities. And if you might speak to what we might expect with these audits.

Jim Gorman: Well, from a data point of view, it's Jim Gorman again. What we're looking at in long term-care facilities, such as yours, are kind of a very, again, simple kinds of things.

Are there services being provided that perhaps the facility, you would expect to see included in facility rates? Are there pharmaceuticals being provided and in what fashion? And, you know, and often we've encountered situations where there's a double provision of pharmaceuticals, simply because of the number that you receive, that your patients receive and sometimes the way they are audited from the pharmacy.

So we're looking at a very high level services. However, when we see questionable claims or activities, if you will, in a facility or a lot of them in one facility and not so many or none in the other facilities, it leads us to direct the auditors to go in on a more comprehensive look, because - just because that seems to be the nature of billing errors. That's how we'll track them down. So that's where we are with long-term care facilities.

Joel Vaneaton: Thank you.

Operator: Your next question comes from the line of MaryAnn Palmeter from Florida.

MaryAnn Palmeter: Hello, can you hear me?

Natalie Highsmith: Yes, we can.

MaryAnn Palmeter: Thank you, thank you for taking my call. I work with a large academic practice plan in Jacksonville, Florida. And we've had some experience with Medicaid Program Integrity Audit and I guess I have a couple - well, I have one question and perhaps one - some feedback that perhaps you might find useful.

One, when we're dealing with large academic practice plans or large group practices, not your one and two provider or practices, we have lots of service

locations. We have lots of providers. And sometimes, mail is addressed to the provider, based on the provider's address of record. Would it be possible to allow us to set up a contact, an individual who will be a contact for the organization, instead of sending the mail to providers at locations on enrollment files?

I find that this would help cut down on misdirected mail and would help us get that request sooner.

Robb Miller: Yes, this is Rob Miller again. That's a very reasonable request. We currently use the primary point of contact as identified in the state enrollment - provider enrollment records. But we also understand that that's not always available. It's also not always up to date.

And so, you know, we've had this discussion with hospitals in particular, that they would like to establish a preferred point of contact. And we would be happy to work with you on that as well. And, you know, get you and the contractor in Florida together. And so they know, if your facility's ever subject to an audit, that there would be a preferred person to contact. We understand. We don't want to lose time in the mail or lost somewhere in your building.

((Crosstalk))

Paul Miner: That's a great suggestion, thank you.

MaryAnn Palmeter: As a follow up to that. Just curious as to how old the records will be that you'll be asking for? Because again, when we're talking with larger volumes of records and older dates of service, they may be stored at off-site warehouses. And so it takes a little bit longer than to just go to the hospital's medical record department and get the chart, if you have to go to an off-site

storage facility, which is the case with a lot of large group practices. (I was wondering) do you allow more flexible timeframes for those.

Robb Miller: Sure. You know, we've always encouraged our contractors to work with the provider, because we know that there could be mitigating or aggravating circumstances, in either direction, depending on the circumstances.

Obviously off-site records or older records could be more challenging to locate. You know, as I said, we're going to be establishing I think a more flexible records production period for the contractors anyway. And then, we would just encourage you to work with the point of contact that the auditor identifies in your notice letter. And if that doesn't work out, you could notify us as well.

And I did want to follow on to the first part of our conversation. The corporate email address Medicaid_integrity_program@cms.hhs.gov , if you want to follow up with that specific question to us, we'll get it routed to the right folks.

MaryAnn Palmeter: Thank you so much.

Robb Miller: You're welcome.

Operator: And your next question comes from the line of Connie Lippincolt from New Jersey.

Connie Lippincott: Hi, this is Connie Lippincott from Virtua. We're in New Jersey and I didn't hear New Jersey being listed as a district. What district is New Jersey going to fall under?

Barbara Rufo: This is Barbara Rufo. New Jersey falls under the Boston/New York region.

Connie Lippincott: Okay. Thank you very much.

Barbara Rufo: You're welcome.

Operator: Your next question comes from the line of Amy Tsui from Texas.

Amy Tsui: Thank you. I have a question regarding when we may be expecting the audit MICs in the - in Texas, in the state of Texas. I understand that was awarded to HMS?

Robb Miller: Well, I'll tell you. We are currently operational in Texas. We have, you know, in excess of 70 audits that are actually underway in Texas right now. And that's an ongoing, you know, each month (additional) leads are provided to the contract.

Amy Tsui: Thank you.

Robb Miller: You're welcome.

Operator: Your next question comes from the line of David Smith from Pennsylvania.

David Smith: Hi, this is David Smith calling from Pocono Medical Center in Pennsylvania. I had a couple questions with regard to your (para complex review).

First of all, do you or will you be reimbursing facilities for the cost of copying charts and mailing them?

Rob Miller: No, this is Rob Miller, no.

David Smith: Okay. And when you do make the request, what sort of patient ID information will you be providing? I know you said you only had (MA Numbers) to do your reviews, but will you be providing date of service, birthdays, that sort of thing? Something that we can cross reference?

Jim Gorman: Yes, definitely. Their date of service, the birth date, the procedure code, the social security number, the Medicaid ID number and the (unintelligible). So...

((Crosstalk))

David Smith: Okay. And may I assume that when you do the complex reviews, you would be using the same criteria as is used by that particular state, in terms of annual use InterQual?

Rob Miller: You know, I did not say that I did not - this is Rob Miller again, I do not have that here at my fingertips, but not necessarily.

David Smith: Not necessarily? Okay. Well, thank you very much.

Rob Miller: You know, feel free to send us a (unintelligible) email to the corporate email box that I listed earlier and we could give you a better specific answer (unintelligible).

David Smith: All right. Thank you. I appreciate that.

Operator: Your next question comes from the line of (Scott Noel) from Texas.

Scott Noel: Good afternoon, hi. This is Scott Noel, Richie and Gueringer. We represent long-term care pharmacies here in the state of Texas and also in Arkansas.

And we're actually representing pharmacies in five different audits. All of which are encompassing a significant number of claims, that range anywhere from 400 to upwards of 8500 claims, dating back four or five years.

So I was particularly interested in how to work with the MICs on whittling down to an informal sample that's much more manageable at the initial level. And then I guess working from there depending upon the findings of that sample.

Jim Gorman: Yes, this is Jim Gorman. When we provide the results to the audit MICs, they get them all. So there can be, particularly in the case of pharmacies, literally 1000's of transactions over a period of time, that don't seem to fit the rules.

We acknowledge and understand that 8000 is an unreasonable amount of records to pull, (in) an additional look. And that's what Robert's speaking about earlier. That we'll have some kind of informal sampling or (crome) probe of that to see if there's any reason to move forward with it, if the data and our assumptions are correct or if they're not. Or if there's something else extenuating that would make them less than valid.

And at that point, we are working with HMS on that. We had discussions - we have ongoing discussions with them on this very issue. And I think we'll come to a satisfactory conclusion for us all.

Robb Miller: This is...

Scott Noel: Do you have the timing - do you know the timing on that, because actually we've got some audits scheduled here or responses due within actually the next week or so here with HMS. And have not seemed to get any response from HMS, other than have all the records ready. So it's troubling on one hand where they say that their orders are to audit all the claims. And as you

indicated, it's unreasonable actually to pull 8500 claims for two weeks, to have six auditors on-site.

Robb Miller: Yes, this is Robb Miller. We - we'll have a specific discussion with HMS about this and, you know, between (unintelligible) and that time. But, you know, we'll -- I'm sure we can work it out in a way that the Integrity of the Audit is not damaged without creating a huge burden on your clients.

Scott Noel: Sure, no, we appreciate that the need to conduct the audit to accomplish certain goals, be at the same time trying to reconcile with HMS to where they feel comfortable with putting together the samples of data to start from and then, work out from there.

Paul Miner: Thank you, Scott. And we will (at) that and we'll have some further discussions offline and we've got to move to the next question now.

Scott Noel: Thank you.

Operator: Your next question comes from the line of (Chuck Wray) from Florida.

Chuck Wray: Hi, I'm actually with All Children's Hospital in St. Petersburg, Florida, and we have actually participated in two audits to date. The first one took place in October of 2008, the second one took place in February of 2009.

When we got the request for records in 2009, I asked about the results of the October, 2008 audit. I was told verbally there were no negative findings. I was also told there would be no report back to me indicating that there were no negative findings. What is the official position on notifying providers when there are no negative findings in the audit?

Robb Miller: Thank you very much. This is Robb Miller again. You know, while there may have been some confusion early on. You know, we are clarifying that with our, both we clarified it internally and we will with our contractors are well. And if in fact there are no findings, you will know that there's no further action that's going to be taken on that.

And I think in the next couple of weeks, we'll be getting information out to facilities like yourself and others too. To -- you know, to make sure that you're all on that same page on that. You've got the right to know that there's no further action taking place. Once we know for sure, that in fact, there won't be.

Chris Wray: Okay.

Robb Miller: Because there is a fairly extensive quality assurance process in turn, but we'll, you know, we will close (unintelligible). And thank you for raising that issue.

Chris Wray: All right. Thank you.

Operator: Your next question comes from the line of Teresa Coyan from Missouri.

Lucas Smith: This is Lucas Smith, Teresa stepped out of the room. We had a question about what states fall within the Kansas City region.

Paul Miner: Sure. Barbara, you have those in front of you, don't you?

Barbara Rufo: (Unintelligible)

Paul Miner: Okay. Go ahead. What are they?

Barbara Rufo: Illinois, Indiana...

Paul Miner: And you said the Kansas City region, didn't you?

Lucas Smith: Correct.

Robb Miller: Yes, that would be, I believe, Kansas, Missouri, Iowa and Nebraska.

Lucas Smith: And then what are the states in the St. Louis or I mean the Chicago region?

Robb Miller: The CMS region five is Illinois and Michigan, Minnesota, Wisconsin, Ohio and Indiana. And, you know, all this information of course is on CMS's Web site as well and there's maps of the whole country (unintelligible)...

((Crosstalk))

Paul Miner: There's 10 states total.

Lucas Smith: Great, thanks.

Operator: Your next question comes from the line of David Risher from Texas.

David Risher: Hello, my name's David Risher in Texas. Actually, I'm Director of Reimbursement for a large network in Austin, Texas. And we've just have finished the fill work on our first audit. But what's surprising (being) based upon your comments describing the program, is the lack of standardization that apparently the MIC audits are being done, compared to the RAC.

That it seems to me that either the sample size or the look back periods should be set by CMS and not be based upon individual state criteria. Because even though states differ in their reimbursement techniques or procedures, it

appears to me it's just creating a lot of confusion, in terms of some of the contractors. I have a second question, too.

Robb Miller: Well, let's talk about your first one there, Richard and then we'll do your follow on. I understand what you're saying. But I would respectfully counter that there could be just as much confusion if we in the RAC were (unintelligible) and then providers in a particular state would be saying well, when the Medicaid program comes out and this, of course, is a Medicaid audit, they're doing it entirely differently.

And I think if there's a tipping point that would tip it over towards more mirroring the state process, it is that the state ultimately has to rejudicate this and recover the overpayments. It is not CMS dealing directly with you. I think if this were the other way around, then I could - then I think that - if the state was not involved in this at all, I would respectfully agree with you.

But I just think that, you know, if (unintelligible) at the end of the day, but it's the direction that we're going at this time. So...

David Risher: I mean, I and I understand that, but obviously I know that y'all will be taking back your piece of the match of the payment, correct?

Robb Miller: We - the recovery of the federal share is part of what's called the CMS core process.

David Risher: Right. Well my next question has to do with just a whole rebuttal and potential appeal process. It seems like it's really not clear and none of the auditors could describe it clearly as to what it is.

Obviously it was before the RAC started and we haven't had our first request for RACs here in Texas or at least we haven't, that is a clearly defined at

different levels the rebuttal process and it seems as though this has been kind of like a work in progress in terms of defining that and I was surprised that that wasn't said before any of the MIC audits started.

Robb Miller: Well the process is that which Texas offers. So if you've ever been audited by HHSC there in Texas the process is going to be exactly like that, that our auditors - that our contractual auditors aren't intimately familiar with the adjudication process actually is not, I mean, yes it would be good if they had a working knowledge of it but it's not overwhelming to me that they don't because they will follow the direction of the state during the adjudication of the appeal.

So it's whatever, you know, whenever you've been audited by the state or if you're ever audited by the state that's what the process will be. The RAC process is immaterial to the outcome of a MIC audit because the state has to handle the appeal certainly.

Operator: Your next question comes from the line of Mark Jacobs from Wisconsin.

Mark Jacobs: Hi. I represent pharmacies that are primarily independent community pharmacies and some long-term care pharmacies. In our experience some of the data that the pharmacy receives for audits does not contain a prescription number. Pharmacies have received spreadsheets with numerous line items of data. Community pharmacies typically retrieve prescriptions by a prescription number.

Secondly, when the pharmacies are audited onsite in a typical audit from a third party an auditor can review 100 to 200 claims in a matter of two to two and a half hours.

During an onsite audit from one of these MICs is this a process whereby they're going to send out a team of three to four auditors that will spend four to five days in a pharmacy or will this be an efficient process that will allow the pharmacy to conduct its normal business?

Jim Gorman: Okay well first I'm - we didn't - we haven't audited or sent out any audits in Wisconsin. So I'm not sure where the question comes from but it - we have run into the issue of not having a prescription number. I think I addressed it initially. If I missed it I apologize. It's one of the data elements that we do not have and have asked for and will have in the future.

But in the interim we do have the data, the transaction, the NBC codes, the social security number, the amount paid, the - other identifying information (unintelligible) and so forth that we're providing on the request.

Now with respect to whether you do it onsite or send the records in I think that that's a judgment call as to how much - what the level of effort and the costs of doing it one way or another.

If we've asked for something that we said earlier is a large number of records and we're correct in our assumptions then it may be to everyone's benefit just to take a sample and settle the issue. If it's not - if it's something that needs to be looked at one on one what's the level of effort of copying that and sending it or having an auditor go out.

We're relying on our auditor's professional judgment for that decision. And I think they're open to doing it either way, certainly the most efficient way. So that's where we are with that.

Mark Jacobs: If you're going to rely on the auditor's professional judgment I'm not sure what the level of experience the auditors have with the practice of pharmacy.

Will there be some sort of external pharmacist review to determine whether maybe the discrepancy in question is one of a technical nature that didn't necessarily result in any overpayment. Is that a possibility?

Jim Gorman: We have, for example before those algorithms - they're developed by pharmacists so these are practicing pharmacists that actually review the algorithms and they get the results of those algorithms before they're sent to the pharmacy. So we - they've already had a look at and a help with design of - by licensed pharmacists.

Now when the audit MICs do it they're supposed to have the clinical expertise available to them along with physicians, nurses - they also have pharmacists consulting on this. So yeah, you'll get a clinical review as well.

Operator: Your next question comes from the line of Jenna Bowman from Kansas.

Jenna Bowman: Hello. This is Jenna Bowman. I'm Director of Records of LaBette Health Hospital in Carson, Kansas. A couple of questions. Will these audits affect Medicaid primary payers or also secondary payers? And secondly will the auditors go through the hospital associations before they start in on state?

Jim Gorman: I'm going to take the take the first part (unintelligible). Well whoever got the money is who we're interested in talking with and so yes, we will be the primary, you know, the primary payee will be the ones who we'll audit.

Jenna Bowman: But if Medicaid is the secondary carrier for a claim they will audit those also?

Jim Gorman: Oh, you're saying if there's some kind of a co-pay from...

Jenna Bowman: Yes.

Jim Gorman: Yeah. Well we're - if Medicaid money is involved wherever it is then we feel we have the right to look at it so...

Jenna Bowman: Okay.

Rob Miller: And this is Rob Miller. As to your second question we have been in communication with the American Hospital Association and we have asked them to help us work with the state hospital associations to push information out, raise awareness, etc. and, you know, I think that your state's association there in Kansas probably already has a lot of information and we'll certainly provide even more as time goes on.

Jenna Bowman: Okay, thank you.

Operator: Your next question comes from the line of Ted Moody from Texas.

Ted Moody: It's more of a recommendation. We went through a big audit with HMS recently and there was a lot of frustration on their side to give us the information to identify which documents to pull for the medical record review.

And I guess they were doing a lot of pointing fingers at CMS saying this is the best that we have and they weren't really able to match up. So maybe get with your contractors and maybe with some facilities to see what data may be works the best to identify the patients.

It seems like they just kind of threw their hands up and said, "This is the best data we have." And they couldn't really give us any more data. So it's more of just a recommendation.

Jim Gorman: Thank you. And this is Jim Gorman and what - we'll talk with them about that. We feel they have adequate and sufficient data. Now I'm not sure when this occurred but we've had ongoing discussions with them about that and I think they have a better understanding of that now.

Ted Moody: Okay. We've been through our third audit and every one of them had brought (unintelligible) so...

Jim Gorman: Okay, very good.

Operator: Your next question comes from the line of Sandy Banks from Missouri. Miss Banks? My apologies. Your next question comes from the line of Minnie Coronado from Texas.

Minnie Coronado: Good afternoon. We're a children's hospital and I'd like to preface my question by stating that we are scheduled for an audit next month and we could not produce the documents in the timeline that we were given on the notification but I do want to commend HMS because they have been very gracious and flexible and working with us in providing those documents.

My question is you stated that you receive information from certain fields on each claim and then you did a rules - you apply some rules and in Texas we're allowed to bill for late charges and a lot of our claims are of that nature.

I wonder why that rule didn't show up and we're going to go through this audit of 600 line items that turned out to be about 300 accounts for us fortunately, but we still have to produce everything.

Jim Gorman: Okay, generally something like that would show up in an electronic audit. If it wasn't - the coding issue would be an adjustment was made and it would look to be a duplicate bill as it came through. And so we wouldn't - it wouldn't - it

isn't a late charge that we would pick up on but we'd pick up on two claims with the same ICN or their equivalent.

It's their equivalent in the data we're looking at and so that's a good thing for us to know. We'll follow up on that with HMS and this is the first I'm hearing of that and find out if we're getting false positives due to some anomaly that occurs in Texas.

And by the way that kind of stuff can happen in any state with unique rules like that. So as we go across from one state to the next we learn things like that which, you know, and there are hundreds or literally probably thousands of variables that we need to take into consideration. So thank you for that one.

Minnie Coronado: Thank you.

Operator: Your next question comes from the line of Shannon McGee from Florida.

Shannon McGee: Hi. I have - in looking at the CMS report on the MIC I notice that the SOW for the MICs was supposed to be out I think some time in 2007 or 2008 and I've not been able to find an SOW. Is there a scope of works?

Barbara Rufo: Hi, this is Barbara Rufo. You probably were looking under the Web site, the federal business opportunity, and what happens after 12 months they archive the data and then they actually get rid of if you will any data after 12 months.

So unfortunately the statement of work is not out on any Web site at this time but just to let you know we are working internal with our FOIA office to try to release some of those documents publicly and what we would like to do is be able to post them on our Web site when we get their approval to do that.

Shannon McGee: Do you have any idea when that will be?

Barbara Rufo: Unfortunately I do not. I can tell you that we are meeting with the FOIA office within the next couple of weeks so, you know, we have to go through their clearance process and I have no idea how long it will take but as soon as we get the approval we will release it on our Web site.

Shannon McGee: Are there timeframes written in the statement of work that identifies or specifies when the MICs should be presenting their findings and how that should occur? Is there any - or any kind of guidelines, written guidelines that the providers can reference?

Robb Miller: We do have both contractual and procedural guidelines and - for, you know, the (unintelligible) of any particular audit but, you know, every audit is - has to kind of stand on its own because it has its own ups and downs so to speak.

In terms of any kind of public information like that there really isn't anything yet but I think that, you know, (Paul) referred earlier to an A to Z document. You know, that's a reasonable I think expectation for providers to have. When should I reasonably know when I might hear back and we can certainly give that some consideration.

Shannon McGee: Okay, and I'm sorry, I have one last question. We were audited and we were told that the - we have a in-state pro and we were told that our pro's determination about what meant medical necessity for admission was not necessarily going to be accepted in the audit as far as medical necessity for admissions.

And so I just want to know is that actually CMS' stance that the in-state pros that are hired by the state don't really carry any weight or they don't carry final weight for what is actually meets medical necessity?

Paul Miner: Okay, can I - we'll answer that question certainly but can I ask what organization you're from? You didn't identify...

Shannon McGee: I'm sorry. I'm hospital.

Paul Miner: I am hospital. Oh, okay.

Shannon McGee: I am a hospital.

((Crosstalk))

Jim Gorman: This is Jim Gorman and this will be a draft answer if you will but I think that the review - the determination of medical necessity of course is a physician's call.

You have your pros look at it and, you know, to make sure that they're making the right decision but at the end of the day, you know, if - in an audit if someone's got to second guess both of them and come up with an answer and if your pros make the mistakes, I don't know what your contract is with them but it's a mistake and if it wasn't medically necessary we're going to throw a flag on it.

Shannon McGee: So I guess that said, it's not our contract with the pro, it's the state's contract with the pro.

Jim Gorman: Okay. Either way then the state's responsible. But we're going to - we have to look at it from the standpoint of was it medically necessary or not.

Shannon McGee: Great. Thank you.

Operator: Your next question comes from the line of Sandy Banks from Missouri.

Sandy Banks: Yes, this is (Sandy Banks), Cedar County Memorial Hospital in El Dorado Springs, Missouri. Hello?

Paul Miner: Yeah.

Sandy Banks: Yes. We were wanting to know - you said that all Medicaid payments would be looked at even if it was secondary payments. What about the managed Medicaid companies? Are you going to be reviewing those payments also?

Jim Gorman: Yeah, we want to take a minute just to sort something out with respect to that question because - we'll be right back.

Woman: (Unintelligible).

Sandy Banks: Well that's why I thought I better grab it up this time.

Paul Miner: Okay, it was a previous question, not this question that we had some concern and we'll address that after this but where - we're looking at, you know, the state's managed care organizations report activities to states. States report activities to us.

The connection between - it varies widely in terms of requirements, reporting requirements for managed care organizations both to states contractually and then the state to CMS simply because it's - there's not a better enforcement anyway of a standard across the country.

So the information we have on a managed care situations vary from very good in some states to nothing in other states and it doesn't really fall in the middle. It skews towards the nothing if anything in terms of the use of that data because there's no standardization of it.

It's one of the things that we have - we're pushing forward with Congress on is to tighten that rule. And then we'll - and we will. In the meantime there are things we can look at. We do have a very comprehensive eligibility file for example.

We can look for carve outs; we can look for services that were provided that were underplanned. We can look at capitation payments, raise to payments, all those kinds of things and we can and we are beginning to look at. So that's the status of managed care and it will continue to get more stringent if you will in terms of what we're able to look at as we get more data.

Jim Gorman: It's just basically the (unintelligible) is basically a work in progress and frankly we're in a better place now than we were perhaps a year ago so it's an evolving thing and we are working on it is the answer.

Paul Miner: Okay.

Jim Gorman: And we wanted to go back then to the previous question. Rob Miller had a comment.

Rob Miller: Sure. The - to the question from the hospital about the PRO review. We just wanted to add that, you know, remind you that the state will have the opportunity to review these findings and we expect that a resolution of any kind of issues like that will be a collaborative process between us and the state, as well as the provider which will have an opportunity to raise any issues it wants.

So while, you know, I - this is still a draft answer as Jim referred to earlier, we will do some more follow up on it but, you know, the - I think there'll be - it's not just a contractor just out there throwing a flag and that's the end of the

story so I just wanted to add that enhancement so folks go ahead with the next...

Natalie Highsmith: Okay, next question please.

Operator: Your next question comes from the line of (Phaedra Simmons) from North Carolina.

Joyce Riggs: Hi. This is Joyce Riggs from Florida from CMC Northeast. My question is, if you pull charts from 2007 to audit are you going to use 2007 criteria or are you going to use 2009 criteria, whether it be Milliman or Intercall?

Jim Gorman: We're going to use the criteria that was relevant at that period of time.

Joyce Riggs: Okay. So you will be using that same year criteria.

Jim Gorman: Yes.

Joyce Riggs: Okay great. Thank you.

Operator: Your next question comes from the line of Susan Allron from New Jersey.

Susan Allron: Hi, I apologize in advance if this question's been asked but I had to step out. Are there any limits to the number of charts or records that can be requested similar to the way the RAC is limiting its medical record requests?

Jim Gorman: Yes, there are none and but - however we'll self-limit if you will for the sake of practicality. Remember that the RACs are coming in with a slightly different business model, the contingency base, their - and they're extrapolating.

What we're trying to do at this point is identify electronically any outlier claims that says - that doesn't meet a business rule criteria. Therefore we could have dozens, hundreds or thousands of them. Our assumption may be correct and it may be incorrect and we'll want to audit to the extent of either proving or disproving that assumption.

So it makes sense to us to - if we identify several thousand claims as was earlier - and there was an earlier example of in a pharmacy. Do we ask for several thousand, 8500 or whatever the number was or shouldn't we just ask for a few hundred, prove our assumption and then maybe work it out with the provider as to how to proceed from there. And that's one method that we think is sensible and we'll be trying out.

Susan Allron: Thank you.

Operator: Your next question comes from the line of Marty Parker from Texas.

Marty Parker: Good afternoon. Thanks for getting to me and I'll just be real quick. I had a few comments and several of them have already been addressed but we noticed that the team leader - we have been through the field work process and the team leaders seem to have a reasonable audit background but did not really have any healthcare experience and in fact did not understand DRG reimbursement which seems fairly basic to this process.

The second thing is we were not told in advance that we would have to be copying and shipping charts and initially were told that they had to be there within two days and that there was statutory authority. We were able to work that out but it would be nice if we had known up front, we would have just made two copies at the same time.

And the last thing that I would say are - is that some of the patients for example, the one they say were targeted and there were quite a few newborns on the list and that would seem to be a pretty obvious one day say that really didn't need an audit.

And I guess the last thing, we - they gave us a internal control questionnaire in compliance with GAGAS but it seemed really irrelevant to a hospital and they did not collect it until the very end of their field work so it was not really used to assess risk which is really the purpose of it according to GAGAS so just food for thought for down the road and that's all.

Jim Gorman: Okay thanks. So I'll take another comment rather than a question and I guess we're - we'll look at all of those situations and we'll try and do better. Sorry about that.

Paul Miner: And we will in fact talk to our auditors about - and our MICs about all of these things and we appreciate the input.

Operator: Your next question comes from the line of Jennifer Abell from Tennessee. Miss Abell, if your line is on mute could you please unmute your line?

Jennifer Abell: My question was what were the three types of contractors that you identified for the different regions?

Barbara Rufo: This is Barbara Rufo. We have the review of provider MICs. They basically help analyze the data with the division of fraud research and detection. We have the audit MICs and then we have the education MICs.

Jennifer Abell: Okay, thank you.

Natalie Highsmith: Okay (Theresa), we have time for one final question.

Operator: Thank you. Your last question comes from the line of Patricia Velky from Texas.

Patricia Velky: Yes, good afternoon. We have a couple of questions. Number one, if there are issues with the auditors what's the process or to whom do we address our concerns? And number two, what is the expectation around supporting the auditors who come onsite unprepared?

Let me give you a couple of examples. We were asked to - asked for a fax number by the auditor and asked if they could fax a document. It's certainly not a problem until we found out the document was 300 pages.

And then they did not come prepared with their audit tools and so we were asked to make copies of the audit tools, again roughly 200 pages. So I'm wondering to what extent your expectation is that we support the auditors?

Robb Miller: Let me address the second question then I'll ask you to repeat the first question because I've been thinking about your second question more. The - we'll certainly talk - kind of like the last caller we'll certainly talk to our contractors about that and, you know, we certainly expect reasonable space to be made for an onsite audit.

You know, we do expect that, you know, there's no reimbursement for making copies of medical records but I don't think that, you know, thousands of pieces of paper to be copied that are, you know, more directly related to our day in day out business.

You know, while I don't think there's a one size fits all answer to what you're talking about I certainly I think we get the gist and the drift of what you're

trying to get across and we'll be talking to our (unintelligible). I apologize. I'm getting - you'll have to go back to the first question (unintelligible).

Patricia Velky: My first question was if we have concerns about, you know, things that we're hearing from the auditors that they're unable to address, some of the concerns have already been mentioned. You know, the timeliness of the turnaround. We had roughly 300 records requested.

They've already identified they're not going to get to those 300 records and so by Friday when they depart their expectation is that we will copy in excess of 100 records and have them on their doorstep waiting for them on Monday. Not a realistic expectation. Where do we address those concerns to have them resolved?

Robb Miller: Sure. In your audit notification there's a - just for any audit, you know, there's a point of contact, a lead person and, you know, I think that working with that person initially is, you know, obviously a reasonable step. If you're not successful there then, you know, you could contact the corporate email address.

We'll put you in touch with the project director for that contractor and we could look at those, you know, and we'll be interested knowing and how that works out as well because we expect our contractors to be reasonable with you and I realize that's a very judgmental thing, very suggestive thing, but if the contractor - if the problem is with the contractor then our corporate email address is the appropriate place to raise that and somebody here in a position of responsibility will look at it.

Patricia Velky: I appreciate that. Thank you.

Robb Miller: You're welcome.

Natalie Highsmith: Okay (Theresa), we're going to go ahead and end the call now. I will go ahead and turn the call over to Paul Miner for closing remarks.

Paul Miner: Folks, I hope you have found this to be useful today. Again this is really one of several activities that we'll be engaging in to try to reach out to you to resolve some of these issues.

Please keep an eye out for some of the materials that we're going to try and push out to you, particularly one that Rob mentioned which was the audit A to Z document - I think will address many of these things.

You have also given us a number of things clearly that we - we're going to look into and do our very best to resolve and until the next time that we talk thank you very much for your participation. Your input is tremendously valuable to us and we value it. Thank you very much.

Natalie Highsmith: Okay Theresa can you tell us how many people joined us on the phone lines?

Operator: We had 1357 participants join us today.

Natalie Highsmith: Okay. Everyone, please remember to use the email address Medicaid_integrity_program@cms.hhs.gov . Thank you.

Operator: Ladies and gentlemen, this concludes today's special open door forum on Medicaid Integrity Provider Audit Program conference call. You may now disconnect.

END