Special Open Door Forum:
Part A Providers, Recovery Audit Contractor (RAC)
November 12, 2008
2:00 PM – 3:30 PM EST

(Conference Call Only)

CMS is hosting this Special Open Door Forum for Part A provider recovery audit contractors (RACs) on November 12, 2008. The purpose of this forum is to introduce providers to the new contractors and provide more information about the RAC program.

Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC Program permanent and requires the Secretary to expand the program to all 50 states by no later than 2010. On October 6, 2008 CMS announced awards for the four permanent RACs. Each RAC will be responsible for identifying overpayment and underpayments in approximately ¼ of the country. CMS has planned a gradual expansion to all 50 states. For further details, visit the website at http://www.cms.hhs.gov/RAC

We look forward to your participation.

Open Door Forum Instructions:

Capacity is limited so dial in early. You may begin dialing into this forum as early as 1:45 PM ET.

Dial: 1-800-837-1935

Reference Conference ID 60225922

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An audio recording of this Special Forum will be posted to the Special ODF website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning November 19, 2008 and available for 30 days.

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.

Centers for Medicare & Medicaid Services
Agenda
Special Open Door Forum:
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1. Introduction– Moderator, Natalie Highsmith, Office of External Affairs (OEA)

2. Welcome & Introduction of Speakers – George Mills, Deputy Director, Financial Services Group, Office of Financial Management (OFM)

3. Presentation – Marie Casey (OFM), Scott Wakefield (OFM)

4. Q & A Session – Moderator, Natalie Highsmith (OEA)

5. Closing Remarks – Scott Wakefield (OFM)

6. Close Forum – Moderator, Natalie Highsmith (OEA)

Audio File for this Transcript:

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

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum:
Part A Providers, Recovery Audit Contractor (RAC)

Moderator: Natalie Highsmith
Conference Leader: George Mills
November 12, 2008
2:00 pm ET

Operator: Good afternoon. My name is (Alicia) 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 Part A Provider's Recovery Audit Contractor.

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 that time simply press star then the number 1 on your telephone keypad.

If you would like to withdraw your question press the pound key. Thank you. Ms. Highsmith you may begin your conference.

Natalie Highsmith: Thank you (Alicia) and good day to everyone. And thank you for joining us for this special open door forum. Today CMS will introduce providers to the new contractors and provide more information about the RAC program. On October 6, 2008 CMS announced awards for the four permanent RACs.

CMS has planned a gradual expansion to all 50 states that will be completed by 2010 as mandated by Section 302 of the Tax Relief and Healthcare Act of 2006. For more details please visit the webpage at www.CMS.HHS.gov/rac, that's R-A-C.

I will now turn the call over to (George Mills) who is the deputy director in the financial services group in CMS's office of financial management. (George)?

(George Mills): Thank you. Yes, this is (George Mills) and again I'm the deputy director of the financial services group of which one of the activities on the financial service group is the implementation of the recovery audit contractors in the Medicare program.

As noted earlier there was an award of four contracts to become the recovery audit contractors. However, there has been a protest filed by two unsuccessful bidders for the RAC program with the government accounting office. And under GAO rules CMS is required to impose and automatic stay in contract work for all four of the recovery audit contractors who were already awarded.

The automatic stay stops works on all four RAC region awards until a determination is made by the GAO as required under the provisions of the Competition in Contracting Act of 1984.

Under the CICA GAO has 100 days to issue its decision which means the decision will be due on these protests in early February. The four RAC contracts and any work under those

contracts performed by the contractors are on hold pending the outcomes of the protest.

So that is probably the biggest breaking news about the recovery audit program. It doesn't mean that the program is going away or it's been dissolved or anything like that. It's just there's a process in place to deal with these protests and we will know more once the GAO makes their decision on the protests.

We had announced a rollout strategy and a timeline. Because of the protests those will have to be adjusted. But in preparing for the financial eventuality of award today we have a presentation from members of the team and we'll take Qs and As concerning the implementation of the RAC from permanent members of the RAC team.

So without further ado I'm going to turn it over to Scott Wakefield and then he'll be proceeded by (Marie Casey) to talk about the implementation of the RAC program. Thank you.

Scott Wakefield: Thanks a lot (George). Yeah, this is Scott Wakefield. I'm the project officer for RAC region B which is most of the Midwest. As (George) explained because of the stay of performance what we're going to do today is just do like a high level overview and discuss some of the background of the RAC program including information about the demonstration and the Congressional authority to move forward with the program.

We'll also discuss RAC procedures, successes with the RAC program and what a provider can do to get prepared for the

programs and (duplication). First let’s talk a little bit about the background of what precipitated the need for the RACs.

The IPIA or the Improper Payment Information Act, public law 107.300 enacted in 2002 requires federal agencies to measure and reduce the proper payment rates. Now improper payments can result in both over and underpayments and we’ll discuss some examples of those a little later on.

But some of the primary reasons include payments made for services and that would be Medicare as a medical necessity criteria. Payments made for services that are incorrectly coded. Providers failing to submit documentation when requested or failing to submit enough documentation to support the claim.

And for other instances like basing claim payments on outdated fee schedules, a provider getting paid twice because duplicate claims were submitted and (Marie Casey)'s going to give you some more examples a little later on.

Of all federal agencies that reported to the Office of Management and Budget in 2007 Medicare ranked third with approximately $10 billion in overpayments. This number becomes somewhat more fathomable when you consider that Medicare received over 1.2 billion claims per year or approximately 4.5 claims per working day.

Let’s look a little bit at the legislation that authorized CMS to run this program. Now section 306 of the Medicare Modernization Act or the MMA authorized the secretary of the Department of

Health and Human Services to utilize RACs to identify in proper payment in a three year RAC demonstration.

This demonstration ran from March 2005 to March 2008 and initially involved just three states. Before the demonstration ended two more states were added. I'm going to provide a little bit more background on the results of the demonstration in just a second.

But we'll also look at section 302, the Tax Relief and Healthcare Act of 2006 which authorized CMS to expand the RAC program nationwide beginning with a limited number of states beginning in the program. The statute requests that the program be nationwide before January 10, 2010.

But before we let any regional RACs start looking at claims once the stay of protest is lifted we're going to do what we're attempting to do here today and that is reach out to the provider community and have the RACs reach out too once the program begins.

The RACs detect and correct path and proper payments to the CMS and the carriers, fiscal intermediaries and MACs, Medicare Administrative Contractors can implement actions that will prevent future improper payments.

This will help providers to avoid submitting claims that don't comply with Medicare rules. It will help CMS lower its error rate and hopefully will protect the Medicare trust fund for future generations. Now again I'd like to take a step back and look at

the RAC demonstration a little bit and some of the results that came from that.

As we just discussed section 306 of the MMA authorized CMS to stage a full and open competition to select three claim RACs and two Medicare or secondary payer RACs. We're going to focus on the claim RACs today.

Initially each claim RAC was given a single stay jurisdiction, California, New York and Florida were selected because they're the largest states in terms of Medicare utilization. The demonstration was expanded in summer of 2007 to include Massachusetts and South Carolina.

The demonstration claim RACs were provided with four years of claims data and subsequently received an additional three months of claims data on a quarterly basis. So in total CMS gave the RACs approximately $317 billion in improper payments over the course of the demonstration.

The demo RACs succeeded in correcting more than $1.3 billion in improper payments and repaid $37 million back to providers in underpayments while costing the Medicare program approximately $178 million in contingency fees.

If you do the math that averages out to about 20 cents paid out to the RACs for each dollar collected. If you want more detailed results on the demonstration they can be found at the RAC webpage given at the beginning here.

So how are the RACs going to select claims? Well the RACs are going to be able to look back three years from the date the claim was paid. Now those that were involved in the demonstration may remember that the RACs went back four years.

But in order to reduce provider hassle which is one of our big, big points that we're going to just try to drive home, we want to reduce the hassle to you so we're bringing that, reigning that in a little bit and just letting them look back three years. The RACs will not be able to review claims prior to October 1, 2007.

RACs are going to choose claims and issues to review based on their data tech mining techniques, OIG and government accountable office, GAO reports and CERT reports, comprehensive error rate testing reports and the experience and knowledge of their staff.

The RACs will perform two types of reviews, much like the FIs, carriers and MACs. They will perform automated and complex reviews. And any new issue for review will be posted to a RACs website before widespread review will begin.

Now once again to reduce provider burden for the national rollout CMS is going to implement a new issues review process. This process will involve having all new issues a RAC wants to pursue for overpayments validated by a CMS review panel.

Once an issue is reviewed it will be shared with provider organizations via the RACs website. In almost instances a RAC cannot go forward with the review until dispensed to the website

for the provider community to see. I'm going to try to walk you through the new issue review process.

Kind of like a quick overview of it because it's a little bit complicated but I have a chart that kind of breaks it down. With automated reviews what essentially happens is the RAC sends new issue, a new issue review request to CMS.

CMS, review panel and CMS will review the issue and decide if it's (unintelligible) if it's valid. If it's approved the issue is posted to the RAC website and the RAC may begin widespread review. All demand letters will be sent after CMS has approved the new issue for review.

Now the process for complex review or requesting medical records is just a little bit more detailed than for automated reviews. The RAC is going to issue a limited number of medical record requests to providers. Normal provider medical record limits will apply.

And (Marie Casey) is going to discuss the medical record limit with you in a little bit more detail. Providers will send the medical records once they received the request. The RAC will review the medical record and then send a new issue review request to CMS.

CMS will then review and decide if the issue is valid. And then if it's approved the issue is posted to a website and RAC may begin wide scale review. Now in cases where CMS is not decided by day 60 whether or not the issue is valid the RAC will issue a limited number of, the RAC can issue a limited number

of review results, result letters without CMS approval and web posting.

That is pretty much the new issue review process as we know it. It's kind of morphing as time goes by. But if you have any questions about it save it for the Q&A session and we'll address them. The medical request process is going to be similar to what you're familiar with.

The difference is the RAC must pay for inpatient hospital records. Failure to submit the requested record in 45 days will result in denial. RACs will send letters requesting medical records just like the carrier, FI, MAC or the CERT. CMS will establish medical record limits.

There will be a web based application which will allow, address customization. And providers can submit medical records via mailed paper copy, fax or mailed CD or DVD. I'd like to discuss now a little bit about reviewing claims.

RACs will use the same Medicare policies as the affiliated contractors for short, that's the FIs, carriers and MACs. That will include national coverage decisions, local coverage decisions and CMS manuals. RACs are required to use nurses, therapists, certified coders and a physician contractor medical director.

During the demonstration they were not required to have a medical director on staff but for the permanent program once again the reduced (unintelligible) they are required to have one.

Each RAC will operate a period of discussions providers for automated reviews.

A discussion period begins with a demand letter and for complex reviews the discussion period begins with the review results letter. Now the discussion period is different from an FI carrier or MAC rebuttal period. A discussion period for a RAC is to discuss the results of the medical review.

Whereas the rebuttal issue is more to discuss mathematical or computational errors on behalf of the affiliated contractor. The discussion period ends on the day of recoupment. CMS suggests that you submit or make a phone call to your RAC if you have issues with the results as soon as possible because the discussion period will not stop recoupment.

The collection process will be the same as for the affiliated contractor identified overpayments. Except the demand letter will come from the RAC. The way that looks, the way that breaks down is day one, if a RAC is looked at a service the carrier, FI or MAC will issue their remittance advice or the RA which will include a remark code N432.

This indicates an adjustment was made based on a recovery audit or a RAC review. Day one, the RAC will also issue their demand letter. So those two things, the RA and the demand letter will come at the same time. That is as usual with the recoupment process on day 41, the carrier, FI or MAC recoups by offset unless a provider has submitted a check or a valid appeal.

Now I’m going to turn this over to my esteemed colleague, Commander (Marie Casey) to talk to you a little bit more about the program. (Marie)?

(Marie Casey): Thanks Scott. I’d like to go into a little bit more detail and break it down for all in the audience regarding the collection process. And I’d kind of like to go through some of the basic steps in the RAC collection process. As Scott had talked about new issues will be posted to the recovery audit contractors website.

And with automated review basically the collection process sort of starts with that, posting of that issue to the RAC website. Then the RAC will make a determination and then we actually go into what we’re calling the collection process in which the carrier, FI or MAC issues that remittance advice.

And Scott had mentioned to you that that remittance advice code is N432. That lets you know that the adjustment was based on a recovery audit contractor determination. Then following that remittance advice the demand letter will be sent to the provider.

And the demand letter will provide information about the amount of money owed and will also include information regarding your appeal rights. And this is the date that the actual interest begins to accrue. Then on day 41 the carrier, FI or MAC will recruit money by offset.

However I’d like to point out that recoupment will not occur if the provider has paid in full or the provider has filed an appeal prior to day 30. Now to go over the collection process for complex

review we would again start with this new complex review issue being posted to the RAC website followed by the RAC issuing what we're calling a medical records request letter.

And that medical request record request letter provides you with a 45 day period to submit medical records. Now there is also an extra 10 days that we include for mailroom time that allows you a total of 55 calendar days to respond to that additional medical request letter.

And you should know that you are entitled to at an extension as long as you contact the RAC and let them know that for whatever you can't find the medical records and you need a couple more days to locate it. They will grant you an extension of that timeframe.

If the RAC does not receive the medical records within that total 55 calendar day timeframe they will deny your claim as no medical records received. Once the actual medical records are received by the RAC a clinician will review the medical records.

The clinician will make a determination on that review. Our recovery audit contractor has 60 calendar days from receipt of the medical records to review that case and respond to you in what we're calling a review results letter. This letter provides you with information as to why the RAC believes the claim is denied.

However, this, it does not have appeal right information nor does it contain any information regarding how much money the RAC has identified as an error. At this point in time if the RAC

did not find your claim to be in error when they did their medical record review basically the process stops.

However if there was an overpayment that was identified the RAC then sends a file to the carrier, FI or MAC. Again you will receive a remittance advice that has that code N432 which says the adjustments based on recovery audit. And then you will receive a demand letter.

And that demand letter just like in the automated process that I described, will have your appeal right information, it will have the amount that you owe and this will be the date that the interest starts to accrue. And then on day 41 again recoupments will take place by offset if moneys are not received.

There are some specific choices that I'd like you to be aware of that you have following receipt of that demand letter. And I'm going to go through them a little bit slowly so everybody has some understanding of those choices.

The first choice is that you can allow recoupment. And that would include the overpayment amount and the interest on day 41. And you can still file an appeal by day 120. Your second choice is to allow recoupment which is the overpayment and interest on day 41 and do not appeal at all.

You can also decide to, once you receive that demand letter, you can pay by check and that check should be paid by day 30 and in that situation your interest would be waived. And you can still file your appeal by day 120. You could also pay the check by day 30.

Again interest would be waived and you can decide that you don’t wish to file an appeal. Your third choice or third selection you could make is that you could actually completely stop the recoupment by filing an appeal prior to day 41. And lastly, you could decide to find (unintelligible) and extend the repayment plan which would include paying for the overpayment amount and interest.

And you can still file an appeal by day 120 or you can sign up for the extended (retainer) plan and decide not to appeal. Just a few reminders about some of the things that Scott and I have discussed with you. I want to make sure that you’re aware that the discussion period is not a substitute for the 935 rebuttal process or appeals process.

So we do want you to be aware that that is something that is available to you to discuss you know why the, why you believe that the RAC may have made an error. Prior to that file getting sent to the FI for adjustment you can discuss you know why you believe page six explains you know why the case should be paid rather than denied.

However, we do not want you to wait around to hear back from the RACs and not proceed with your request for an appeal. Again we also have the rebuttal process that Scott mentioned to you.

If you have any questions about you know the calculation that was used by the carrier or FI you would utilize the rebuttal process that we’ve had in place now for years to get those

corrections made to those calculations in the situation in which your claim has been denied.

For the new automated review issues we want you to be aware that those issues will always be posted to the RAC website before the demand letter is sent. And new complex review issues will usually be posted to the website before medical record request letters are sent.

And the reason why I said usually is I want to point out that we are requiring that the RAC do a very small sample size prior to doing a widespread review. We want to make sure that the issues that are, they are bringing to CMS that they are truly legitimate issues and that their medical documentation definitely does not support payment of that claim before the contractor goes out and does a widespread audit on that particular issue.

So we are requiring that on complex review that they provide CMS with a small 10 to 20 claim sample size that provides us with the information we need for them to make, for us to make a good decision on whether they should do a widespread review.

So you maybe receiving, there maybe some things that won't be posted to the website that you may receive a medical record request letter for but it will be for a very small sample size.

As Scott mentioned I am going to talk to you a little bit today about some of the problems that we actually identified during the demonstration so that you have an understanding of some of the things that we're going to be expected to see with the

types of reviews that the RACs makes for (unintelligible) to audit.

And so that you can have an understanding when you see in our status report what a medically unnecessary service is or what we mean by incorrect coded claims. One of the first examples is our very short hospital stay example.

And this is a situation in which the beneficiary presented to the emergency room and they were complaining of shortness of breath. However, the EKG was completely normal, chest x-ray ruled out any signs of pneumonia. The hospital actually admitted the beneficiary for a one day hospital stay.

However, when the RAC did the medical record review they found that there was no justification for that patient to be in the inpatient stay. So the RAC collected an overpayment during the demonstration for the full amount of the stay.

So that is an example for you of what CMS is classifying as an unnecessary, medically unnecessary service or a medically unnecessary (setting). The next example is an example of incorrect coding. This is a situation in which the DRG was improperly upcoded for hospital care.

And the example is that the hospital, or the provider submitted the claim with a diagnosis of (hepidemia) and the medical record shows that the actual diagnosis was not (hepidemia). It was (uroseptis). All the cultures were negative and the contractor, the RAC decided that the diagnosis if it had been

correctly coded, the claim would have paid at a lower DRG amount.

And the overpayment that was collected, it's the difference between the wrong code which, and the right code. So again that gives you an example of an incorrect, an incorrectly coded service. And lastly, one of the examples is what we call our other category and you'll see this listed in our status document.

An example of something that we've classified in our other category is a duplicate claim. And this is the situation in which the physician submitted two claims for the same beneficiary for the same service and the Medicare costs, claims processing contract are paid both claims.

And the overpayment was for the full amount of the second claim. As we move forward with national expansion CMS believes that there are three keys to success. And I'm going to go through each one of those three keys to success.

The first key is that we believe that it is vital that we minimize provider hassle. And we've taken some significant steps to insure that we do minimize hassle. And the first step is that we've limited the RAC look back period. The regs actually CMS, or Medicare regulations actually allow us to look back four years.

However in the recovery audit contractors statement of work we've limited this to three years. We also are in the process of our continued development of a medical record reflects limit that all RACs are going to be required to implement.

And we've also set the maximum look back date for recovery audit contractor reviews 10/1/07. And lastly, we hope to minimize provider hassle by insuring that the RACs will be willing to accept image medical records on CD.

The (agency) and the RAC program is also committed to insuring that we maximize transparency. And we claim to do this in the national program by issuing those new issues that Scott mentioned and I had also elaborated on. We will post those new issues to each of the RAC websites so you're aware of what types of widespread audits the RAC is going to be performing.

We also plan on posting vulnerabilities that meet a certain dollar threshold to the website so we can provide you with some information as to what the greatest vulnerabilities really were.

Also we hope to by, or actually a requirement in the RAC statement of work is that all RACs have by 2010 a claim status website in which the provider can actually log into a database and be able to track where exactly a recovery audit contract or process their claim is (unintelligible).

So with the mailroom or is it with the new reviewer or exactly what the status of that claim is. And lastly, we hope to maximize transparency by providing detailed review result letters to you to help you to better understand why the RACs believed your claim was in error.

The third key to success in the RAC program we believe is to assure accuracy. We make changes to the RAC statement of

work to insure that we are trying to insure the accuracy of the RAC. And the first change we made to the statement of work actually required that the RAC had to hire a physician medical director.

This was not a requirement as Scott had previously mentioned in the demonstration, but now is a requirement. Also the RACs are now required to hire certified coders. We also have the new issue review board in place. This review board will hope to provide greater oversight to the types of audits that the RACs are performing.

And we also have hired our RAC validation contractor which will on an annual basis produce accuracy pools for each of the recovery audit contractors. And lastly, if a recovery audit contractor loses at any level of appeal the RAC must return their contingency fee.

Many of you maybe wondering how you can prepare for a RAC so I'm going to go through some of the things that we believe at CMS will help you to prepare for the recovery audit contractor program. We encourage all of you to checkout our demonstration findings that are listed on the www.CMS.HHS.gov/rac website.

This provides information in detail on what types of improper payments the RACs (unintelligible) during the demonstration program. We also as we go forward with the national program, we will also be posting all of the permanent findings of the RAC program on our web pages as well.

So again if you'd like to see the demonstration RAC findings you can look at those at the www.CMS.HHS.gov/rac website. And in the future we will be posting similar information on the RAC web pages. Also, we highly recommend that you look at OIG and CERT reports.

And again those things are publicly available for you. The OIG reports can be found at www.OIG.HHS.gov/report.html. And our CERT reports which stands for comprehensive error rate testing reports can be found at www.CMS.HHS.gov/cert.

And again these two improper payment, or excuse me, these two reports that are published provide a good idea where improper payments may exist in the Medicare program. One of the next things that CMS has, believes that would be helpful to you in preparing for the RACs is we recommend that you conduct your own internal audits and determine for yourselves what rules or regulations you may not be compliant with.

Also we recommend that you identify internal corrective actions that you can take to insure that in the future you will not have Medicare improper payments.

One of the most important things that we can recommend that you do is that you insure that as we rollout the program nationally that you tell your recovery audit contractor the site's address and contact person that they should use when sending medical record request letters.

We found that this has been extremely important during the demonstration project, that there's actually a person at your

particular facility that those medical record request letters get sent to.

Early on in the demonstration we had some issues in which medical record request letters were floating around to all of the departments in the hospital and not getting to that medical record clerk that actually pulled the medical records and got them to the RAC in time. So this extremely important.

Also we recommend that you continue to make sure you're checking on the status of the medical records. Did the RAC actually receive it? And again we found that this was very important during the demonstration project. A few times you know providers thought they sent the medical record and the RAC never really got it.

If they would have just picked up the phone and made the phone call there wouldn't have been as many issues with the no receipt of medical records. So again those two things we really feel are important for you to insure that you implement (unintelligible) national program.

And lastly we believe that the appeals process is an important process. If you believe the RAC has not correctly, or made an incorrect decision on the review of your claim we think it's important that you understand the appeals process.

And we, again they'll want you to complete the RAC discussion period with our appeals process. And if anytime you disagree with the RAC determination don't stop with sending the

discussion letter. File your appeal before the 120 day period has ended.

So with that I at this point in time we'd like to take some questions. Or actually I'd like to turn it over to Natalie.

Natalie Highsmith: Okay. (Alicia) we're ready to go into our open Q&A portion of the call. If you could just remind everyone again on how to get into the queue to ask a question. And everyone, when it is your turn please remember to restate your name, the state you are calling from, what provider or organization you are representing today.

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. Our first question comes from David Smith. Your line is open.

David Smith: Hi. Actually I had a couple of questions if I may. I just wanted to clarify a couple of things. First with regard to the number of records that are being requested per hospital. Our facility has a cancer center, a psych area, cardiac rehab, inpatient medical.

Would the maximum total for our facility for 45 days be 200 or would it vary depending upon which venue they were looking at?

Scott Wakefield: Hi David this is Scott.

David Smith: Hi Scott.

Scott Wakefield: First I'd like to point out that we are still working with the American Hospital Association to set these limits. We've already issued something stating what the limits are but I'd say at this point we're still not solid on that. Under the scenario that you presented though yes. The maximum is 200.

David Smith: Well that's a good thing. My other question is with...

Melanie Combs-Dyer: I'm sorry David this is Melanie. I work with Scott. Let me just ask do you have multiple NPIs for the different parts of your organization? Or...

David Smith: Yes, ma'am. We do. We have one tax number but there are multiple NPIs.

Scott Wakefield: Well that kind of changes, that kind of changes that scenario then. Mel what is your understanding...

David Smith: Is it not a different one for the site? I'm being corrected. I apologize. We don't have multiple NPIs.

Melanie Combs-Dyer: So the medical record limits that CMS has issued so far are by NPI. And unless and until we change what's out there the limits will be per NPI. Now there have been some discussions about trying to find a way to have it so that if there are multiple NPIs for one organization and you're all located on the same campus it would be one limit for all those different pieces and parts.

But for right now it is whatever the limit is per NPI.

David Smith: My other question was regarding the review process. I understand that while in the past I was exposed to the PRO process in which they used a specific intercall criteria when they reviewed medical records. I was wondering one, if that was something that was going to be continued with the RAC process.

And secondly under the process then if there was a question with regard to medical necessity a physician had an opportunity to talk to another physician usually within the same specialty, for example if it were a chest pain case a cardiologist would be able to talk to a cardiologist at the other end.

Has anything like that been looked at or being considered?

Scott Wakefield: Well I'll answer those questions separately David. The review process intercall, that really, that's kind of dependent on the RAC. There are different review processes. The RAC will determine which one they're going to use or have already determined which one they're going to use.

And then they will eventually publicize that. You may not hear it at first but sooner or later you'll see that, what exactly they are using. The RACs will have as I explained before, they will have a medical director on site full time. And they will also have clinicians for each specialty.

Again it's kind of dependent on the RAC but it's in their best interest to have you know somebody to address each area. So I would assume that it may not be the, a doctor per se but they

will have somebody that will most likely be able to address each area.

Natalie Highsmith: Okay (Alicia), next question please.

Operator: The next question comes from Ginger Reding. Your line is open.

Ginger Reding: Yes, this is Ginger Reding. I'm with UCSF Medical Center in San Francisco. And what I'd like to know when you say you're going to post the issues to the website is that going to be by facility? Is that going to be possibly a daily occurrence? Or is it just in general across the nation? How's that going to be...

Scott Wakefield: Thanks Ginger. The RACs will be required to post each new issue to their website as the new issue, after it goes through the new issue review process. It'll have to be posted before they can go out and start reviewing claims. So I would assume it would be in their best interest to get it up as soon as possible.

Whether that's a daily basis or not we can't say really. That speaks to the, the processes of a RAC and we don't know what exactly is going to happen just yet.

Ginger Reding: So will that be facility specific or will it just be a general issue?

Scott Wakefield: It will be issue specific, not facility specific.

Ginger Reding: Just issue. So you...

Scott Wakefield: Keep in mind that the RACs look at issues. They don't look at specific facilities when they're out there mining for these issues.

Ginger Reding: Okay. So it could be an issue from any RAC across the country or would it just be your own RAC only posting their issues?

Scott Wakefield: It's done regionally Ginger. It would be whatever...

Ginger Reding: So they could post and issue and possibly go to your facility for it or not, you won't, you won't really know?

Scott Wakefield: You'll know when your receive the demand letter. I would...

Ginger Reding: Okay.

Scott Wakefield: ...say.

Ginger Reding: Okay. Thank you.

Scott Wakefield: Sure.

Operator: The next question comes from William Malm. Your line is open.

William Malm: Yes. Thank you very much. The first question, and they're both financial questions. The first question we have is like CFOs, is that if we successfully...

Scott Wakefield: William?

William Malm: Yes?

Scott Wakefield: Let me interrupt you for just a second. Let's do this one question at a time. As my co-worker (Marie) likes to say I can only

answer one question at a time. I will never remember the first one after you pose the second. So go ahead with your first question.

William Malm: The first question is we are completely successful in an appeal and the RAC returns their funds back to the system. The cost associated with the hospital having to appeal that is there anyway that we would be able to recoup those costs either on the cost report as an allowable cost or other method?

Scott Wakefield: Not that I'm aware of.

William Malm: Okay. And the costs associated with the actual appeal or anything are they considered allowable costs? In some cases with like project bad bundle at the OIG they said those were unallowable costs. We need to know if we can put these costs such as overtime and the costs to pursue this on, as an allowable cost.

Scott Wakefield: No. I don't believe they are William.

William Malm: Okay, thank you.

Scott Wakefield: Sure. Thank you.

Operator: The next question comes from Joel Vaneaton. Your line is open.

Joel Vaneaton: Thank you. My name is Joel Vaneaton. I'm with Care Center Management in Johnson City, Tennessee. I represent nine skilled nursing facilities. And a couple of questions specifically I don't hear any reference to (SNIFs) in the conference call today.

And I was wondering first of all when a (SNIF), when issues are identified and records are requested from (SNIFs) what are we talking about as far as a sample or a number of records that maybe pulled at one time or requested at one time from a (SNIF)?

Scott Wakefield: From a (SNIF) we're looking at 10%, we are currently looking at 10% of your average monthly Medicare claims for 45 days going forward from the start of the program, not going back. And with a maximum of 200 per NPI, different campuses as Mel explained earlier.

Joel Vaneaton: 200 claims per NPI?

Scott Wakefield: Yes.

Joel Vaneaton: Okay.

((Crosstalk))

Joel Vaneaton: ...you all went through fairly quickly some guidelines there just at the beginning of the conference call in terms of timeframes and notifications and so forth. Is there anyway that that's actually laid out in guidelines or somewhere we can read and notice process a little bit better?

Scott Wakefield: Joel the process is going to work the same as it does for the, for the FIs and you know for the affiliated contractors, for the FIs and carriers and MACs. That is laid out actually and I, Mel can you cite a specific reference, point of reference for him?

Melanie Combs-Dyer: I think it's just in the regular claims processing and other manuals that CMS has put out. Joel were you looking for something specific to the RAC?

Joel Vaneaton: Yeah, because I mean some of the timeframes and appeal deadlines and so forth were a little bit different.

((Crosstalk))

Joel Vaneaton: ...demand letter I mean that's something that's different as well. I mean...

((Crosstalk))

Joel Vaneaton: ...different process than the actual process of medical record review that happens with the typical FI or MAC.

Scott Wakefield: Well actually Joel the appeals process works exactly the same. The only difference is the RAC issues the demand letter.

Joel Vaneaton: Okay.

Scott Wakefield: So your timeframes are going to be the same. If you want to e-mail me, let me give you an e-mail address. It's...

Joel Vaneaton: Okay.

Scott Wakefield: It's Scott, S-C-O-T-T dot Wakefield, as it sounds, W-A-K-E-F-I-E-L-D at C-M-S dot H-H-S dot gov. If you want to e-mail me with that question I can send you a chart that...

Joel Vaneaton: Yeah. That would be helpful.

Scott Wakefield: Sure.

Joel Vaneaton: Yeah, I mean we do, we do plenty of med review just with the FIs. It just seemed to me some of the deadlines, some of the timeframes were a bit different you know in terms of the, in terms of the actual, when things were due and so forth.

And then the last question I have is, is in looking through this, this report that came out, the recovery audit contractor program, the three (unintelligible) evaluation demonstration report, said that, that skilled nursing facilities represented 2% of the total amount of overpayments.

Are you all familiar with maybe some of the issues that had been presented with this niche that we reviewed?

Scott Wakefield: Joel I will actually go around the room a little bit and we have a cast of thousands here on the RAC team. And there are people that can address that better than I. So (unintelligible).

Woman: (Marie) do you remember (unintelligible)? I can recall a few issues but did you have something in particular that you wanted to discuss or bring to our, and are you looking for information about specifics from CMS or are you aware of specifics?

Joel Vaneaton: No I'm, what I'm curious to know is what was found, what was, what might have been issues that were identified you know as you went through and did these RACs.

Woman: I think we did have some issues with, there was no qualifying inpatient hospital stay.

Joel Vaneaton: Okay.

Woman: I know that was one of the issues.

Joel Vaneaton: So with, at the (SNIFs) you were looking at both Part A and Part B claims?

Woman: I'm sorry. I'm having a discussion...

Woman: Yes. Both Part A...

Joel Vaneaton: Okay.

Woman: ...and Part B claims.

Joel Vaneaton: Okay.

Woman: I'm thinking of another issue with an issue with therapy services. We're not being billed correctly. That's a big one.

Melanie Combs-Dyer: Yeah, this is Melanie. I think on the therapy issue that the coding is supposed to be billed per session and some (SNIFs) were billing per 15 minutes. And so...

Joel Vaneaton: Oh.

Melanie Combs-Dyer: ...if it was a 45 minute session they would bill for three of them.

Joel Vaneaton: Okay.

Melanie Combs-Dyer: It may have been speech language pathology.

Woman: It was. That was one of our...

Melanie Combs-Dyer: Okay.

Woman: ...largest areas.

Joel Vaneaton: Okay.

Woman: And we also did have some problems with no documentation being submitted or insufficient documentation submitted that there was just not enough evidence in the medical records with the RACs to make up review determination.

Joel Vaneaton: Did, did you find issues, I'm sorry, this is my last question, did you find issues related to medical necessity issues per se just across the board on those kinds of services?

Woman: The RACs really did not, on many of the (SNIF) services they really didn't look at medical necessity that closely. There was not, in terms of that we collected data on at central office...

Joel Vaneaton: Okay.

Woman: ...there were not that many medical necessity issues that they looked at. They were mostly coding.

Joel Vaneaton: Okay. Thank you.

Woman: Coding or billing issues.

Joel Vaneaton: Okay.

Operator: The next question comes from Missy Sutton. Your line is open.

Missy Sutton: Hi. My name is Missy from St. Genevieve, Missouri. And our question is will they recoup the entire claim or will it be a partial recoupment with like critical, we're a critical access hospital so how will they recoup our funds?

Scott Wakefield: Well it's done at the line level or the service level Missy. Does that answer your question? So they may not, I'm sorry, let me respond a little bit, because they may not go for the entire claim but a service or line on the claim. And then the rest of the claim is available to the RAC for review.

Missy Sutton: Okay. So if we're paid per daily, per diem, per day like you know let's just throw out $1,500 and they said a CT scan shouldn't have been performed how would they recoup that if we're paid on a per diem?

Melanie Combs-Dyer: This is Melanie. I'm not sure how that works but there is someone in the room who thinks she does. Go ahead.

((Crosstalk))

(Cindy Murphy): This is (Cindy Murphy). I work in claims processing for institutions and I believe that they will look at what the, your reimbursement is an interim payment, that's what that per diem is. What they would be doing is taking back against your final cost settlement.

Missy Sutton: Okay. So it would probably be finalized at cost settlement time rather than a recoupment immediately.

(Cindy Murphy): I believe there would be some recoupment on the, in the immediate issue but the final resolution would not come until cost report settlement.

Missy Sutton: Okay. Thank you very much.

(Cindy Murphy): It would depend in part on whether we're talking about Part A or Part B services in the (SNIFs). We are still in (SNIFs) aren't we?

((Crosstalk))

Missy Sutton: ...just in general. Right.

(Cindy Murphy): I'm sorry.

Scott Wakefield: Missy my understanding, this is Scott again. My understanding is that if the cost report is settled the regular demand letter will, it'll go through the regular process. And if no payment is sent in we'll recoup. But if the cost report is open we'll take into effect when the final (PSNR) is settled. Does that help?

Woman: (Unintelligible).

Woman: For those who, who are not critical access hospitals and might have a more generic question about whether the RAC will do a partial recoupment or a full recoupment let me just try to answer that in general. It really depends on what they find.

For example, on the inpatient hospital side if they find that the admission was not necessary you heard (Marie) talk earlier about a short, one day stay. Perhaps the person needed to have some kind of services in the outpatient side but they didn't need to have an inpatient admission.

That full amount would be denied. Now the provider perhaps could rebill for some of the outpatient services but that would be a separate claim that would need to be submitted if the timeframe were still open for that.

On the other hand, if the recovery audit contractor finds that the provider billed for (excisional debrevement) when they should have billed for (nonexcisional debrevement) and changing that procedure code from the incorrect one to the correct one changes the DRG from a high paying DRG to a low paying DRG.

The recovery audit contractor will recoup just the difference between the high one and the low one. So it really depends on the situation in bold about whether the recovery audit contractor is collecting the full amount or collecting just the difference.

Scott Wakefield: Does that help (Cindy) - Missy? I'm sorry.

Missy Sutton: Yeah. It did. We just, can you, if you're going to appeal the claim can you rebill for the medical services at a lower level of care? Or should you do your appeal and then rebill later?

Scott Wakefield: You cannot rebill.

Woman: Actually if there are some ancillary services on an inpatient claim it's my understanding that if the timeframe is still open and you can follow all of the other normal claims processing rules there maybe some services that you can submit a new claim for.

Missy Sutton: Okay, thank you.

Operator: The next question comes from Wendy Grove. Your line is open.

(Gary Portman): Yes. This is (Gary Portman) for Brooks Health System in Jacksonville, Florida. On the information previously published regarding the RAC outreach education sessions I know they've been postponed but there was only one session schedule for Florida that we saw and that was in Fort Lauderdale.

We're in Northern Florida and I was just wondering will there be more than one location or will the provider be required to travel to the sessions?

Scott Wakefield: I think that's, I think that's pretty much up to the provider associations and CMS and the RACs to decide (Gary).

(Gary Portman): Okay.

Woman: Generally speaking I think there will probably be one session in each state before a RAC begins. But after the RAC begins there can certainly be second sessions and third sessions and fourth sessions and you may be seeing a lot of us in the RAC.

(Gary Portman): Okay, thank you.

Operator: The next question comes from Mary Staub. Your line is open.

Mary Staub: Hi. This is Mary Staub. I'm from Inter Mountain Health Care in Salt Lake City, Utah. And my question is regarding certified coders. Could you give me your definition of a certified coder? As you know there are different certifications that are out there.

And it would be helpful to know whether you're talking about AHIMA certification or CPCs. What is your definition?

Scott Wakefield: Mary it's good that you mentioned that. We've been having a lot of discussions about that on this end as well. And who is our coding expert here?

Man: Would you like to (unintelligible).

(Pam Durbin): Hi, yes, this is (Pam Durbin). And I'm a nurse consultant for the RAC program. And it is our understanding that anybody that has taken a certified coding exam whether it's from AHIMA which has the CPS, the CCA and the CCSP or whether it comes from a CPC hospital or a CPC provider. Those are all certified coders. Or the CRNC is also out there as well.

Mary Staub: Thank you very much.

(Pam Durbin): You're welcome.

Operator: The next question comes from Patrick Kennedy. Your line is open.

Patrick Kennedy: This is Patrick from Nash Healthcare Systems in Rocky Mountain, North Carolina and I've got two questions. The first being the issues that you mentioned that would be posted to the RAC website. You said early on that the issues would be posted to the website but then during the complex reviews there maybe a small sample size of reviews that would not be posted to the website.

So as a provider we're just curious how could we tell the difference? How do we know that this particular issue has been approved by CMS for the RAC to review?

(Marie Casey): This is (Marie Casey). We are still in the process of developing our new (interreview) process. One of the things we may consider is that when the RAC sends out the additional documentation request letter we can possibly let them know that the new issue has not been approved yet for widespread review.

But you know this claim that we're, the information that we're requesting is part of our sample that's selected as part of the new issue review process to determine if we want to do the widespread review.

So that maybe something that we will consider so that you are aware that yeah, this is not one of the claims that is going to be a widespread review yet. It's just something that they're sampling to see if there is a problem.

Patrick Kennedy: Okay.

Melanie Combs-Dyer: This is Melanie. Just to follow up on that if that does not happen, if the letter does not spell that out then you'll know by looking at the website if you get a medical record request letter for wheelchairs and you look on the website and there is no new issue posted for review of wheelchairs you know you just happen to be one of the lucky few that the recovery audit contractor chose to select, to justify their new issue review request letter that's going into CMS.

99% of the time when you get a medical record request letter you will find the new issue posted to the RAC website.

Patrick Kennedy: Okay. And my second question is regarding physicians, whether physicians are affiliated with an organization or whether they're independent how are they going to be reviewed or involved in the RAC review? Or is that, that's something different?

Scott Wakefield: Well Patrick if I understand your question again I mean they request medical records by NPIs. So I don't know if that's responsive or not. Restate your question.

Patrick Kennedy: I guess if they were requesting records by NPI and let's say just for instance, physicians are affiliated with an organization, a

hospital and they have their own NPI number, obviously they're billing differently. Then how are their reviews going to be done? Or will they be done?

Melanie Combs-Dyer: Patrick this is Melanie. And I think the easiest thing to keep in mind is who's doing the billing? If the physician is an employee of a hospital and the physician is not submitting any claims it's the hospital who's billing on behalf of that physician then it will be the hospital who will get the medical record request.

And it will be the hospital whose job it is to track down those medical records and submit them to the RAC. On the other hand if the physician is submitting claims to Medicare they will be the ones who will be asked to find those medical records and submit them to the recovery audit contractor.

Patrick Kennedy: Okay. That helps.

Operator: The next question comes from Robert Corrato. Your line is open.

Robert Corrato: Hi folks. How are you today?

Scott Wakefield: I'm fine. Thank you.

Robert Corrato: Excellent. I have a question for you in follow up to Dave Smith's earlier question regarding Intercall.

If our hospital organization is using Intercall or any other inpatient criteria screen review and that case met the inpatient

screening criteria for medical necessity for inpatient and the RAC subsequently denies that case because it is not using such screening criteria, what recourse do we as a provider have from a Medicare appeals process perspective?

We'd assume we're following the rules by using an accessible screening criterion and here the RAC may not necessarily be using the same.

Scott Wakefield: Well again Robert I mean the RACs will post, eventually post what screening process they are using but I don't think there's any recourse to the best of my knowledge in the appeals process. I think it can be mentioned but I don't know whether it would be, whether it would carry much weight on the appeals side. So...

Melanie Combs-Dyer: Robert this is Melanie again. I think what's important to keep in mind about Intercall is that it is just a screening tool. A recovery audit contractor cannot deny a claim just because it fails Intercall or any other screening tool.

And nor should anyone assume that just because a claim passes Intercall or any other kind of screening tool that the service is covered by Medicare. It's just an indication that it's more likely that that claim is covered by Medicare or if it fails that it's not covered by Medicare.

So it's really up to each hospital to use Intercall plus whatever other information it can get from the fiscal intermediary and the other Medicare policies and manuals. And make sure that they are billing consistently with all of that.

And the recovery audit contractor whether they're using Intercall or they're using some other tool will be making sure that they do not deny the claim just because it has failed the criteria. But only in those instances where the nurse reviewer has looked at it and believes that there is no justification for that service or for that service to be performed in that particular setting.

That being said you can always appeal the claim and you can appeal to whatever level you believe is appropriate.

Robert Corrato: No, thanks. Thanks I appreciate that. One final question, could you comment briefly if you wouldn't mind just on the whole concept of extrapolation and how that will be used by recovery audit contractors?

Scott Wakefield: Well RACs generally don't use the extrapolation process. I believe they may. Is that correct Mel? Okay. But they, I don't think there are any examples of it during a demonstration Robert to be honest. So I can't foresee a lot of it going on in the future.

Melanie Combs-Dyer: This...

Robert Corrato: Okay.

Melanie Combs-Dyer: This is Melanie. The demonstration RAC did not use extrapolation just like Scott said. But it was available to them. They could have if they wanted to. And the permanent contractors again can use extrapolation if they want to.

The important thing to keep in mind here is that the recovery audit contractors would have to abide by all the same requirements that are currently in the program integrity manual about extrapolation and when it can be used and how it has to be based in a specifically valid random sample.

And there has to be a statistician involved and all those other requirements the recovery audit contractor must abide by.

Robert Corrato: And who ultimately would give their approval on the methodology for extrapolation if a RAC wanted to pursue that at some point in the future?

Scott Wakefield: I think that would go through the new issue review process. And be handled accordingly.

Robert Corrato: As opposed to the FI or MAC then?

Scott Wakefield: I'm sorry?

Robert Corrato: As opposed to the fiscal intermediary or MAC then? You're saying that would be a new issue review issue.

Scott Wakefield: Yes.

Robert Corrato: Excellent. Excellent. Thanks, thanks very much folks.

Scott Wakefield: No problem. Thank you.

Operator: The next question comes from Maryann Pike. Your line is open.

Maryann Pike: Thank you. This is Maryann Pike. I'm with Catholic Health Services of Long Island in New York and I have a question about the appeals process. We'd like to know that if we submit an appeal within 30 days we're now holding, we can hold onto our revenue until the appeals process goes through the second level, up to the ALJ level.

My question is if the FI agrees with us or the MAC will we be receiving a letter with a favorable response?

Melanie Combs-Dyer: This is Melanie and I don't think anybody in this room is well enough versed in the appeals process to be able to answer that question. All we can tell you is that whatever the appeal rules are the same thing will happen with your RACs and (unintelligible) plans.

Scott Wakefield: And that's a good point Mel. Maryann let's ask a question, let's answer a question with a question. In the past have you received letters?

Maryann Pike: No. And the problem that we have now is in the demonstration project they took the money back right away so we didn't have the 30 day timeframe.

And the issue now is since they're going to hold the recoupment, since we can hold onto the recoupment if we appeal how are we going to know if we haven't received a denial letter are we going to assume that they approved the case if we don't get a letter? In the past they did not give us letters if it was a favorable decision.

Melanie Combs-Dyer: Again this is Melanie. And all the rules have changed. There was a particular statute that I'm sure you're very well aware of, MMA section 935 which put in place this new process for the halting of the recoupment process if a provider appealed within the first 30 days.

Maryann Pike: Right.

Melanie Combs-Dyer: And so whatever the new rules are will apply to not only carrier and FI denials but also denials by the RAC. But whether or not you will get a letter telling you that your appeal has been approved I really don't know.

If you want to submit an e-mail we would be happy to get you to the right person in our field shop who can answer that question for you.

Maryann Pike: That would be great.

Melanie Combs-Dyer: Let me suggest that you use the e-mail address RAC@CMS.HHS.gov.

Maryann Pike: Thank you.

Operator: The next question comes from Jane Klugman. Your line is open.

Jane Klugman: Hi. I think all my questions were answered already. Thank you very much.

Operator: The next question comes from Elise Smith. Your line is open.

Elise Smith: Thank you. I'm Elise Smith with the American Healthcare Association. I just have a few points or questions. I'll do them quickly and Scott, I'll do them one at a time.

Scott Wakefield: Thank you.

Elise Smith: First, a point I would like to make is that a lot of the problems that transpired in California under the demonstration I think came from a huge gap between what the FIs were doing and the RACs were doing regarding the same claim.

That is to say a kind of a glitch in communication which led to a glitch in appeals and this horrendous process problem. So I would recommend, I would ask that this be monitored and laid out very, very carefully.

As a matter of fact Scott, I thought you did a fine job in your briefing of you know the FI or the MAC does this and then the RAC does this and the appeal goes this way and then that goes that way. And you've already been asked if you would lay this out in some document and the response was well it's all out there.

You know the appeals is here, the what's it is there. I would recommend because your presentation was very logical and clear that somebody simply listen to this thing again and type up what you have and post it. I mean you can do an internal review of it but it was concise and I think some help is really needed that way.

That was my first point, no question. The second one is new issues and that is a question. What do you mean by new issue? Are you just going to post every issue as it comes along if it's not the same as the prior one? Or are you talking about issues that may not have really even seen in some way before? Or am I not getting this quite?

Scott Wakefield: No. I mean I think you're getting it. New issues as they come up and are approved by CMS, issues involving improperly paid claims will be posted to the RAC website once they're approved by CMS.

Now it's the provider's responsibility and before I go any further, thank you for all of that about the presentation. That's, I'm patting myself on the back here for that.

You know it's a provider's responsibility to keep an eye on those websites, to go into those websites as often as possible to look for new issues and then act accordingly once they see them. I mean if you see that a new issue posted to a RAC website you know is applicable to what you're doing then you know I would...

Elise Smith: Okay. Then...

Scott Wakefield: ...I would follow up.

Elise Smith: ...what you're essentially, what you're essentially, what you're essentially saying is that most all issues will be posted, same issues won't be repeated and you're not just talking about novel issues.

Scott Wakefield: Yes. I think...

Elise Smith: Okay.

Scott Wakefield: ...that that's an accurate assessment. Now you know as (Marie) stated earlier I mean it's, a lot of it is provider outreach but again it's the provider's responsibility to keep track of that. So check on the website.

Elise Smith: All right. That brings up the next point which is very important, provider outreach. I hear a lot about working with you know the hospital association and sessions for hospitals and all the rest of it.

I am presuming in each state that the new RACs go into they will reach out to all providers and give ample time to all providers whether it takes one meeting or two meetings or whatever. Are you going to make sure that all provider sectors really do enjoy similar outreach?

Scott Wakefield: That is our intent ma'am. But I mean it won't always come in the same form. Of course we're limited by budgetary constraints so you know we're going to try to do as much face to face as possible. But there's also teleconferences, you know that we experience here today.

And you know there's other means out there, there are other mediums out there. So we, we want to try to explore everything and we want the RACs to be you know very transparent in their efforts. So...

Elise Smith: Right. I would hope they would be very balanced and very transparent which leads me just to one more point. I would like to work with someone at CMS on the medical record limit for (SNIFs).

Scott Wakefield: I would recommend that you use the e-mail address that...

Elise Smith: No. I really would prefer a name. I understand that you're working with the hospital association. Do you wish me to call you Scott?

Scott Wakefield: Sure. You can call me or send anything directly to me and I will pass it onto the appropriate folks. We do have a panel that's kind of, a team that kind of looks at that or is looking at it. So that would be great. You can use me as your liaison. That's fine.

Elise Smith: Great.

Woman: Elise?

Elise Smith: And I only have one last question. What is Melanie's last name?

Melanie Combs-Dyer: Elise this is Melanie Combs-Dyer. C-O-M-B-S - D-Y-E-R. And Elise I had a couple of points. You and Scott were going back and forth so fast I couldn't get a word in edgewise. The process that you were talking about couldn't we listen to this tape and write it all down.

We actually are doing that. We are putting together a flowchart actually to try to describe the processes that you heard Scott and (Marie) talk about and how many days is it out for medical

record request and then how long does the RAC have to review it and all that.

And we have been having some conference calls and internal meetings trying to make sure that we all understand that chart and that it makes sense to providers. And once we feel comfortable with that chart I would anticipate that we would be posting that to our website.

I hear you giving us one more vote for posting that to our website as soon as possible. And we will, we will try to get that out as quickly as we can. We do...

Elise Smith: I think that is terrific because now you remind me that I did hear someone refer to charts. I think it was Scott. He was going to e-mail it to someone. And what I was going to ask if it also be mailed to AHCH, me. But if what you're going to do is hold onto it a bit longer and perfect it that's fine.

But that chart, it would be deeply appreciated.

Melanie Combs-Dyer: Absolutely. You also asked what the definition of a new issue is. And I think that we've actually talked about some of them here today. For example you may have heard Scott talk early on in his presentation about duplicate claims.

It would be my expectation that all four RACs would submit requests to CMS to get permission to review duplicate claims right off the bat and I would anticipate that CMS would probably approve that one pretty quickly. And those would be one of the first new issues posted to each of the RAC website.

You then heard (Marie) talk about short stays and patients who are admitted to, for an inpatient stay when there was no documentation in the medical record to justify that. It's very possible that a RAC could submit that as a new issue. CMS...

Elise Smith: Right. I'm just thinking in (SNIF) terms.

Melanie Combs-Dyer: Okay. The speech language pathology, the people who are billing three evaluations when they should only be billing one. Those are the kinds of things that a RAC will come to CMS, ask for permission and once we grant it, it will show up as a new issue on the new issue list on the RAC website.

Elise Smith: Okay. Well thank you very much. And I look forward to working with all of you.

Melanie Combs-Dyer: Thanks Elise.

Scott Wakefield: Thank you.

Operator: The next question comes from Sandy Lakey. Your line is open.

Sandy Lakey: Thanks. This is Sandy Lakey. I'm with the Aspirus Wasau Hospital in Wasau, Wisconsin. My question has to do with the look back period. You referred to 10/1/07. Is that date of service or date of paid claim?

Scott Wakefield: I believe that's date of, date of service? Hold on just a second please Sandy.

Man: We've been looking at paid claim dates for all of our timeframes, not dates of service.

Sandy Lakey: Thank you.

Natalie Highsmith: (Alicia), next question please.

Operator: Yes ma'am. The next question comes from Wanda Taylor. Your line is open.

Wanda Taylor: Yes. Wanda Taylor, Palmetto Health. This is an easy question. The presentation tomorrow, is it going to be the same presentation position?

Scott Wakefield: Yes, it is Wanda.

Wanda Taylor: Thanks. And one more question. I'm getting some e-mails from folks that couldn't get in. Are you going to have more lines than the 150 tomorrow or could you have more lines?

Natalie Highsmith: We have, we don't have a minimum of, we don't, we have more than 150 lines. There will be a transcript of this call posted on the special open door webpage and also as links for the audio file as well that will be posted by the 20th.

Wanda Taylor: Will that include the questions and answers though?

Natalie Highsmith: Yes. The transcript will have, it will be the entire call.

Wanda Taylor: Oh, great. Thank you.

Natalie Highsmith: You're welcome.

Operator: The next question comes from Jodi Atkinson. Your line is open.

Jodi Atkinson: We'd just like to clarify critical access hospital. And there was a reference to DRGs. And a critical access hospital not being reimbursed on DRGs would be a per diem, per day. And so for this discussion let's say that a CDC was billed out with no order.

Melanie Combs-Dyer: I'm not sure that we, oh (Cindy) do you think you can answer it?

(Cindy Murphy): No. I was going to ask a question. Are we talking about an inpatient claim or an outpatient claim?

Jodi Atkinson: Inpatient.

(Cindy Murphy): I think we still have some question about how that would be handled because that per diem is in fact an interim payment and you're not going to receive your final payment for that inpatient stay until cost settlement.

Jodi Atkinson: Right. And I guess I heard something that referred to if you had an open cost report versus a closed cost report?

Scott Wakefield: Yes.

Jodi Atkinson: I apologize. I'm from the state of North Dakota and we're about two years I suppose open.

Scott Wakefield: And under about 15 inches of snow I heard.

Jodi Atkinson: Absolutely not. We only have four.

Scott Wakefield: That's a lot.

Melanie Combs-Dyer: (Jodi) maybe the best thing to do would be for you to submit your question in writing and let us make sure that we have the right people look at it and we will get back out to you with an answer and we can post it to our FAQ website so that everybody can see the answer to that.

Jodi Atkinson: Thank you.

Operator: The next question comes from Jane Williams. Your line is open.

Jane Williams: Hi, yes. Will the RACs be following the official coding guidelines?

Scott Wakefield: I believe they will. Yes.

Jane Williams: Okay. Because with the (excisional debrevement) I had heard that the RACs in New York needed the word (excisional) but coding clinic says cutting away or sharply. All that counts as an (excisional).

(Marie Casey): Actually during the time that the RACs reviewed the claims for (excisional debrevement) the coding clinic guidance that actually was out there did kind of indicate that the term (excisional) didn't necessarily have to be there but other things such as you know the wound (ed) margins had to be defined.

And it had to be, you know the wound had to be cut away using a sharp instrument. However the coding clinic guidelines now have changed and there's an example actually now that indicates in coding clinic that you know as long as the term (excisional) is somewhere in the medical documentation that the coder is to code that claim as (excisional).

So as we move forward with a national program the RACs will be relying on that new coding clinic guidance to assist them in their review determination. However, I do want to point out that a RAC can also make a medical necessity determination.

So for instance if that (excisional debrevement) is truly not medically necessary as evidenced by other supporting documentation in the medical record these RACs could deny that case as not reasonable and necessary. And it would be an RNN denial versus a coding denial.

Jane Williams: Okay. Thank you very much.

(Marie Casey): You're welcome.

Melanie Combs-Dyer: And this is Melanie. I just want to remind people that that's a very good example that (Marie) just gave that points out how the policy can change or the guidelines can change over time. I believe that in the four year time, look back time period that our demonstration RACs had, the coding clinic rules about (excisional debrevement) changed more than four times.

It was actually quite difficult to follow. But what's important to remember is that whatever the date of service is the RAC will be

looking to the guidelines that were in place at that time. And that's what the provider will be held to.

So even though the rules are changing, whatever the rules are on the books at the time that you are providing the service to the beneficiary, those are the rules that you should be abiding by as you're documenting in the medical record and submitting your claim.

Operator: The next question comes from Denise Blaine. Your line is open.

Denise Blaine: Hi. Yes, thank you. I'm calling to try to find out about the requirement in 2010 for the claim status website. You know where the providers can go onto the RAC. But I wanted to, in reference to that can they do it sooner than the 2010?

And also how do we go about making first code service options? Are MAC accountable for their 60 day you know timeframe at looking at our appeals or whatever the timeframe is?

(Marie Casey): Hi. This is (Marie). I can address your first question. And your first question had to do with when the website that you can log into and find out the (unintelligible) that the claims will be made available. I can tell you that a requirement of our statement of work only requires that the RACs have that available to be used by the provider community by 2010.

So we as an agency really can't hold them to establishing that sooner than that. However, I can tell you that a lot of them are interested in establishing that website quickly. However, we can not hold them to anything prior to 2010.

Melanie Combs-Dyer: And this is Melanie. I will add to that the recovery audit contractors are required to verbally provide you with a claims status if you pick up the phone and give them a call. So even though the website won't be available the information will be available immediately.

Scott Wakefield: And if I may add to that Mel that's why we emphasize getting a point of contact at the RAC and providing a point of contact so this process flows a little bit more easily.

(Marie Casey): And to answer your second question, unfortunately everyone in the room does not really have the authority to speak on behalf of our appeals division here at CMS as to what kinds of performance related issues may come into play when the appeals community does not perform their review in the required timeframe.

Melanie Combs-Dyer: But just like before, send us an e-mail and we will get it routed to the right person. Again the best e-mail to use is RAC@CMS.HHS.gov. And let us know your question and we will get it routed to the appeals people.

Denise Blaine: Thank you very much for your time.

Operator: The next question comes from Cheryl Petersen. Your line is open.

Cheryl Petersen: Yes. I'd like to go back to try and clarify an earlier question that we heard. And this had to do with physicians and what would happen with them. Is my understanding correct that the RAC

audits are only looking at facility billing for both inpatient and outpatient and they are not going to be looking at claims like physician professional claims?

Scott Wakefield: We are, CMS does not determine what issues the RAC's going to look at. That's pretty much up to them. So I would not put parameters around it and say that they're not going to look at a specific issue.

Melanie Combs-Dyer: Cheryl this is Melanie. The recovery audit contractors will be given all of the Medicare claims for their jurisdiction that were build to the fee for service Medicare program. So HMO Medicare is off the table, prescription drug benefit is off the table.

But every other claim type is on the table and available to the RAC for review should they choose to pursue it.

Cheryl Petersen: Including individual 1500s for physician professional claims?

Melanie Combs-Dyer: That is correct. There, during the demonstration program the physician evaluation and management services, the visits, the hospital visits and the office visits were off limits to the demonstration RAC. But that will change under the permanent program and the permanent RACs will be able to review any and all services billed by a physician or any other provider who bills the fee for service Medicare.

Cheryl Petersen: So for a physician like, we're an academic medical center. We have 750 physicians all with individual NPIs. Are you saying that

they could request 25 claims for however many days for each one of those NPIs?

Terri Lee: This is Terri Lee. I'm on staff at the RAC program. I've been working with medical record request limits. For single providers billing individually the limit is going to be five records. We are trying to struggle...

Woman: Five?

Cheryl Petersen: Five per what...

Terri Lee: Ten.

Cheryl Petersen: ...timeframe?

Terri Lee: 10. 10 per 45 days. My apologies. As we've touched on earlier we are struggling with some NPI issues. Our goal is to come up with limits that are reasonable for everyone. We're not trying to overwhelm an institution with multiple NPIs.

We're not trying to give a pass to an institution that covers multiple city, states, counties, what have you and only give them a single low limit. So we are trying to come up with something that's fair and we have to ask that you be patient as we work on that.

But we'll certainly do our best to keep you and everyone out here posted once we do finally come to, come to our decision.

Cheryl Petersen: Okay, thank you.

Natalie Highsmith: Okay (Alicia). We have come close to our 3:30 hour here on the East Coast. I will turn the call over to Scott Wakefield for closing remarks.

Scott Wakefield: Thank you. Yes, I'd just like to remind everybody to keep lines of communication open. Once the protest is resolved and the RAC program is implemented fully establish your lines of communication, establish your contacts and please do not hesitate to contact CMS if you have remaining questions or questions as a result of answers that we've already provided.

I'd like to thank everybody and remind you that provider outreach still remains one of our primary goals in the RAC program. So transparency and provider outreach are two of our biggies. And hopefully vehicles like this will provide the information you need going forward with the RAC program.

Thank you everybody and please contact us if you have any remaining questions.

Natalie Highsmith: Thank you everyone again for joining us. (Alicia) can you tell us how many people joined us on the phone?

Operator: Yes ma'am. We have 592 participants.

Natalie Highsmith: Wonderful. Thank you and tomorrow will be the Part B provider's RAC open door. Thank you. And see you all.

Operator: This concludes today's conference call. You may now disconnect.

END