Special Open Door Forum:
Part B Providers, Recovery Audit Contractor (RAC)
November 13, 2008
2:00 PM – 3:30 PM EST

(Conference Call Only)

CMS is hosting this Special Open Door Forum for Part B provider recovery audit contractors (RACs) on November 13, 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 60227754

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

dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here http://www.consumer.att.com/relay/which/index.html . A Relay Communications Assistant will help.

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 20, 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 – Ebony Brandon (OFM), Gia Lawrence (OFM)

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

5. Closing Remarks – Ebony Brandon (OFM)

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

Audio File for this Transcript:

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

CENTERS FOR MEDICARE AND MEDICAID SERVICES

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

Moderator: Natalie Highsmith
Conference Leader: George Mills
November 13, 2008
2:00 pm ET

Operator: Good afternoon. My name is (Amanda) 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 B Provider's Recovery Audit Contractor.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during this 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. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you (Amanda) 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. For further details you can visit www.cms.hhs.gov/rac, R-A-C.

I will now turn the call over to George Mills who is the Deputy Director in our Financial Services Group and our Office of Financial management. George.

George Mills: Thank you. Again, this is George Mills. I'm the Deputy Director of the Financial Services Group under which one of the activities we have is Recovery Audit Contractors.

Before we turn to our formal presentation today, I just wanted to say a few words about the RAC program. The RAC program has not been stopped, repealed or permanently delayed. But as previously mentioned, CMS had awarded four RAC contracts in October; however, protests have been filed by two unsuccessful bidders for the RAC program with the Government Accountability Office.

Therefore because of the protests, the Centers for Medicare and Medicaid Services is required to impose an automatic stay on the contract work of the four Recovery Audit Contractors.

An automatic stay will stop work for all four RACs until a determination is made by the GAO as required under the provisions of the Competition and Contracting Act of 1984.

Under the Act, the GAO has 100 days to issue a decision on the protest, which means a decision would be due for these protests

about mid February. So four RAC contracts and work of those awarded contractors are on hold pending the outcomes of the protest. So that is when people hear about issues in terms of delay with the program, it all relates to protests.

But we'd like to move forward today and get some information because as soon as the determinations are made on the decision, we definitely will be moving forward. So without further ado, I'd like to turn it over to Ebony Brandon who will start our formal presentation for today. Thank you.

Ebony Brandon: Thanks George. Good afternoon. My name is Ebony Brandon. I am one of the project officers for Region A of the RAC program. Today's presentation will focus on five questions. What is a RAC? Why do we have RACs? What does a RAC do? What are the provider options? And what can a provider do to get prepared?

Some background. I'm sure most of you know that Federal agencies are required to measure the improper payment rates under the Improper Payment Information Act. When we say improper payments, we are referring to both overpayments as well as underpayments.

The Congress required a RAC demonstration under the Medicare Modernization Act Section 306. That was a three-year demonstration. It ran from March 2005 to March 27, 2008.

The permanent program operations under the Tax Relief and Healthcare Act of 2006 Section 302. We are required to have the program permanent and nationwide by January 1, 2010.

That date is still in affect even though we currently have the pause.

Both statutes gave CMS the authority to pay RACs on a contingency fee basis and those fees are posted to the Web.

The program mission always has been and always will be to protect and correct cash improper payments so that CMS carriers, FIs and MACs can implement actions that will prevent future improper payments.

This will in turn allow the provider to avoid submitting claims that don't comply to Medicare rules. CMS will be able to lower its error rate and taxpayers and future Medicare beneficiaries are protected.

Just some information about the demonstration findings. CMS gains a RAC $317 billion in paid claims data. The demo RAC found $1 billion in improper payments. They actually repaid $37 million to providers and 6.8% of the RAC determinations were overcharged and appealed.

However that number will change. Some appeals from demonstration are still going through the appeals process and that information will be posted to our Web until all the appeals from the demonstration have been made.

RACs are able to look back three years from the dates the claim was paid. And the demonstrations they were allowed to look back four years. However, in permanent programs, we have a

maximum look back date of October 1, 2007. The will not be able to look back any further than October 1, 2007.

RACs choose areas of focus based on their own data mining techniques. They review OIG, GAO, certain reports and of course they rely on the experience and knowledge of the staff.

There are two types of review. There's automated and there's complex. Automated reviews do not require a medical record. Complex reviews require the RAC to request the medical records from the provider and they have to review those medical records within 60 days.

New issues for review will be posted to the RAC Website. All proposed new issues come from the RAC. They go - the come to CMS and they have to be approved by CMS. Once they are approved, the new issues will be posted to the RAC Website.

RACs must pay for inpatient hospital records. They are not required to pay for other records. Failure to submit those requested records within 45 days equals an automatic denial. We encourage providers to please get those medical records in within the 45 days or call the RAC and ask for an extension because we really do not want to have to have denials based on not receiving medical records.

The rest - the letters that the RAC sends for medical record requests, they look exactly like the letters you receive from carriers, FI, MAC or CERT. The only difference would be is it would have the RAC logo on that letter.

CMS has established medical record limits. Those are posted to the Website. We are still working with the AHA and AMA on those limits so they may change. When they change, they will be posted to the Website as well.

CMS is requiring the RAC to have a Web based application that will allow address customization. That's not - they have to have that in place by January 1, 2010. That will allow providers to go in and actually put their address and contact information in for the person that will receive the medical record request letters.

Providers can submit medical records by mail paper copy, they could fax the letters or they can mail them on CD, DVD.

RACs use the exact same Medicare policies as FIs, carriers and MACs. They use national coverage determinations, local coverage determinations and CMS manuals. They are also required to use the same types of staff as FIs, carriers and MACs.

Nurses, therapists, certified (quotas) and they're required to have a full-time physician CMD on staff.

Each RAC will offer a period of discussion to providers. For automated review, discussion period begins with the demand letter. Once you receive that demand letter, you are able to call and discuss with the RAC the claims and any supporting documentation you want to submit.

For complex, that discussion period date begins with the review results letter. Like I said, during the discussion period, you are

able to provide additional information to the RAC to support your claim. However, the discussion period ends on the day of recoupment.

So we suggest contacting the RAC as soon as possible if you believe you have more information that could change the status of that claim.

I'm now going to turn it over to Lieutenant Gia Lawrence.

Gia Lawrence: Hello everyone. I'm going to start with the collection process. Basically the collection process with the RAC program is going to be the same as the carrier, the FI and any MAC identified overpayment. The only difference is that the demand letter is going to come directly from the RAC.

The carrier that, the FI, the MAC will issue remittance advice. You will note that there should be a special code on there that's called N432 and the title of that is Adjustment Based on Recovery Audit. This is a little different so if you don't see this code when you receive the remittance advice, the first thing you want to do is reach out to the carrier, the FI or your MAC.

At that point you - the RAC will issue the demand letter and then the carrier, the FI, the MAC will recoup via offset.

So basically the collection process for automatically - for automated review, there is no medical record request. For complex review there is a medical record request. So those are basically the differences between automated and complex.

You have a few choices after you have received the demand letter. You can allow recoupment. You can pay by check. You can stop recoupment by filing your appeal. Or you can sign up for an extended repayment plan.

Next I'm going to review with you some examples of improper payment. The first one is an example of a medially unnecessary service or study. Short, very short hospital stay.

So we have a beneficiary who presents at the emergency room with shortness of breath. The EKG is normal, the chest x-ray rules out pneumonia. So the hospital admits the beneficiary for a one-day hospital stay.

The RAC in turn reviews the medical records, determines there is no documentation to justify the inpatient admission so we have an overpayment in this city for the full amount of the stay.

Looking at an example of incorrect coding. This is one where there's a DRG improper up coding for hospital care. So we have a provider who submits a claim with septicemia as the diagnosis. However when review of the medical records shows that the diagnosis is actually uroseptic, not septicemia and the blood cultures are negative.

Had the diagnosis been coded correctly, the claim would have been paid at a lower DRG amount. So here the overpayment is the difference between the wrong code and the right code.

Example of other improper payment. The (duplictic) claim. Physician submits two claims for the same beneficiary for the

exact same service. The Medicare claims processing contractor paid both claims. So here we have an overpayment in full amount.

We learned a lot from the demo. We've made some improvements we feel will be extremely beneficial as we transition into the permanent program. So to minimize provider hassle we have limited the RAC look back period to three years. In the demo the look back period was four years. We have also limited the number of medical record requests and the RACs will accept image medical records on CDs or DVDs.

To maximize - I'm sorry, to maximized transparency, we are requiring that all new issues be posted to the Web. The vulnerabilities posted to the Web. RAC claim status Website should be up and running by January 1, 2010. And a detailed review results letter following all complex reviews.

To ensure accuracy, each RAC is required to hire a physician medical director, certified coder. The CMS has issued a new issue review board to provide greater oversight of the RACs. Also a RAC validation contractor that will establish annual accuracy (board) for each RAC.

And also if a RAC loses at any level of appeal, it must return to contingency phase.

So what can you do to prepare? First thing you can do is look to see what improper payments were found by the RAC. Demonstration RAC findings you can access the Website at www.cms.hhs.gov/rac.

Permanent RAC findings will be listed on the RAC Web page list. You can look to see what improper payments have been found in OIG and CERT reports. Checking the OIG report Website at www.oig.hhs.gov/report.html. CERT report, you can access this information on their Website, www.cms.hhs.gov/cert.

You can also conduct a general assessment within your own facility to identify if you are in compliance with Medicare rules. Identifying and corrective actions is also a good thing that you can do to prepare to make sure that you're also in compliance.

You might want to think about providing in services or refreshers for your staff on things such as coding (planned) guidelines or the importance of listing the correct principle diagnosis on all claims.

Other things you want to do. Tell your RAC support precise address and contact person that they should use when they're going to be - when you're going to be sending out medical records with (class) letters. That way they will have the correct information so that they'll know directly who to send the information to. Eventually by January 1, 2010 you can use the RAC Website.

When necessary check on the status of your medical records by calling or emailing. Also you want to keep track of any denied claims, look for patterns and determine what corrective actions you need to take to avoid improper payments in the future.

If you have any additional information or questions you may have, you can submit them to our RAC mailbox, rac@cms.hhs.gov and you can also check our Website out, www.cms.hhs.gov/rac.

Natalie Highsmith: Now we are ready to move into our open Q&A portion of the call. (Amanda) if you can just remind everyone on how to get into the queue to ask their question and 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.

Operator: At this time as a reminder if you wish to ask a question, please press star and the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

The first question's from (Alan Goldberg) from Virginia. Your line is now open.

(Alan Goldberg): Thank you. What a pleasant day. I am an attorney representing providers of healthcare. My question follows. One of the challenges that we have faced in behalf of providers with Part B carriers in particular is the inability to have any in the face interface.

That is the inability to see a human, to even get a return phone call or otherwise interact in a personalized manner with respect to questions, concerns and substantial confusion that on occasion arises in an alleged disallowance circumstance.

Will the RAC as you've described it be more forthcoming, more gracious and more welcoming of human being interaction?

Ebony Brandon: (Alan), yes. The RAC - if you contact the RAC, they are required to return a phone call within one business day. In the permanent program, if a provider is calling during the discussion period or at any time to discuss a determination, they are required to let you speak to the medical director or the person that reviewed that claim.

(Alan Goldberg): Thank you.

Ebony Brandon: You're welcome.

Operator: Thank you. The next question's from (Karen Brown) from South Carolina. Your line is now open.

(Karen Brown): Good afternoon. Thank you for offering this teleconference. My question has to do with the production of medical records for Part B providers. I understand that we will be reimbursed for medical records for inpatients but not Part B. Is that correct?

Ebony Brandon: Yes.

(Karen Brown): Is there a reason for that because some of these charts could be rather cumbersome.

Melanie Combs-Dyer: This is Melanie Combs-Dyer. I'm a colleague of Ebony and Gia's. And the rationale for paying inpatient hospital providers for their production of medical records and not submitting - not paying others for their submission of medical

records has to do with the way that the fee structures were originally built.

The cost of supplying medical records theoretically is built into the physician fee schedule and other fee schedules for non-inpatient hospital providers and therefore no additional payment is made to providers for the production of those medical records.

(Karen Brown): Thank you very much.

Operator: Thank you. The next question's from (Debbie Willis) from Arizona. Your line is now open.

(Debbie Willis): Yes, good morning. I'm wanting to know when we would be notified about the automated review. If there isn't any records entailed, how would we know other than you requesting your money back?

Ebony Brandon: That is the way that you would know that a determination was made. You would receive a demand letter from the RAC. If there was no findings, then you would never be contacted by the RAC.

(Debbie Willis): So we wouldn't know about any automated reviews unless something was wrong.

Ebony Brandon: Correct.

(Debbie Willis): Okay.

Melanie Combs-Dyer: This is Melanie again. The other thing to keep in mind for automated reviews as well as complex reviews is that the Recovery Audit Contractor will be posting to their Website the list of issues that they are going to be reviewing.

So you would know by looking at the RAC Website that for example they are reviewing, you know, Level 3 E&M codes or wheelchairs or whatever it is that they are reviewing, you will know that that's something that they're subjecting to automated review.

But you will not know that they have reviewed one of your until like Ebony said, you get the demand letter.

(Debbie Willis): Okay. So just basically go to your Website once a week or everyday or...

Melanie Combs-Dyer: That will depend on the RAC and how often they update their Website. Any new issue that they're going to review has to be posted to the Website. So you can, you know, make your own schedule. Do you want to, you know, check once a week or if you want to check every day. That's up to you.

(Debbie Willis): And what was that Website address again.

Ebony Brandon: The new issues will be posted to the RAC Website. So once the RACs are in place and we start doing (corotta) outreach, you'll know what the RAC Website is, address is.

(Debbie Willis): Thank you very much.

Ebony Brandon: You're welcome.

Operator: Thank you. The next question is from (David McClure) from Tennessee. Your line is now open.

(David McClure): Yes. This is (David McClure). You've already answered my question. It was about the payment for medical records. Thank you.

Operator: Thank you. The next question's from (Melinda Wilson) from Wyoming. Your line is now open. (Melinda Wilson) from Wyoming, your line is now open.

(Melinda Wilson): Okay. My question has to do with three-day stays qualifying for SNF. If the three-day stay is denied, that it's not medically necessary, is the - still the SNF part of the stay also denied for the nursing home or the swing bed in the hospital?

Melanie Combs-Dyer: This is Melanie again. And it is my understanding that the Medicare policy is that if a - if there is no three day inpatient stay prior to a SNF day, then the SNF day would be considered non-covered. So I'm not sure if the RAC will choose to do those reviews, but I believe that conceptually, theoretically they could if they wanted to.

(Melinda Wilson): So are you saying that if they've denied the three day stay that they will also deny the skilled nursing stay or the swing bed stay. Is that correct?

Melanie Combs-Dyer: I would think I would - I would say they may. I don't know that they will.

(Melinda Wilson): Thank you very much.

Operator: Thank you. The next question is from (Loretta Hervell). Your line is - from Wisconsin. Your line is now open.

(Loretta Hervell): I have a question in regards to the denial process. If a potential denial is identified say in a patient admission, will that be reviewed by a physician prior to ever - prior to any denial or demand letter being sent out?

Ebony Brandon: No, the RACs are required to use registered nurses for a medical necessity denial. Now they do have a CMD on staff and I'm sure he will play a huge role in medical necessity reviews. But they're only required to have a registered nurse.

(Loretta Hervell): Okay. I'm thinking of like the old QIO program where, you know, they always had to have a physician look at the case before a denial could go out. In this case they will not.

Ebony Brandon: Correct.

(Loretta Hervell): Thank you.

Operator: Thank you. The next question is from (Marsha Siebold) from Maryland. Your line is now open.

(Marsha Siebold): Hi there. (Marsha Siebold) from Maryland. My question is, and I'm sort of new to this so sorry if this is sort of a basic question. This - so the RACs can look at any type Medicare A or B?

Ebony Brandon: Correct.

(Marsha Siebold): Okay. What about the Medicare Part D?

Ebony Brandon: No.

(Marsha Siebold): So it's just A and B.

Ebony Brandon: Yes.

(Marsha Siebold): Okay. Thank you.

Ebony Brandon: You're welcome.

Operator: Thank you. The next question's from (Karen Insulo) from Florida. Your line is now open.

(Karen Insulo): My question was already answered.

Operator: Thank you. The next question is from (Lisa Johnson) from...

(Lisa Johnson): Yes, hi. How is everybody? Thank you for taking my call. I have two questions. I'm sure the answer is no but will we need a business associate in relation to HIPAA with the RAC?

Ebony Brandon: No.

(Lisa Johnson): Okay. And then just getting a confirmation on the date span of the review because it was said a couple of different ways. Will it

be that they'll go back effective until 10-1 of '07 because there was also mention of three years?

Ebony Brandon: The maximum look back date is October 1, 2007. Eventually we will get to a three-year look back period. So right now it's not a full three years.

(Lisa Johnson): And then during the time when the RAC is reviewing the facility and they review hypothetically 10 patient charts, will they then be extrapolating and estimating based on total amount of Medicare patients seen by that facility? Or is it per case per charts that they review?

Melanie Combs-Dyer: This is Melanie again. The Recovery Audit Contractors both in the demonstration program and in the permanent program have the ability to perform extrapolation. However, during the demonstration program, none of our demonstration RACs chose to follow the extrapolation process.

We don't know yet whether any of our permanent RACs will choose to do extrapolation. But if they do, they will have to follow all of the same instructions that our regular carriers and FIs and (MACs) have to follow about choosing a statistically valid random sample using a statistician and all the other requirements for using extrapolation.

(Lisa Johnson): Will the providers be offered the availability for conversation after the RAC has a determination if we disagree with findings?

Ebony Brandon: Yes. That's the discussion period that we talked about earlier.

(Lisa Johnson): Okay. So it's 45 days, 45 or 60 days after?

Ebony Brandon: No. Once you receive that demand letter or overview results letter in the mail, if you want to discuss with the RAC because you disagree, you need to do that as soon as possible.

(Lisa Johnson): Okay. And then do you know at this point, is it involving any of the Medicare Advantage products?

Ebony Brandon: No. No.

(Lisa Johnson): Just straight Medicare at this point.

Ebony Brandon: Yes.

(Lisa Johnson): Okay. Thank you. That's it.

Operator: Thank you. The next question's from (Cathy Bolmar) from Tennessee. Your line is now open.

(Cathy Bolmar): Hi. My question is a timeframe within which the RAC has to complete the review and give the facility back or the provider back their determination. We have a demonstration RAC review where a number of records were requested months and months and months ago and we've never heard anything back.

Ebony Brandon: They have 60 days. And in the permanent program, you will receive a review results letter for each medical record requested.

(Cathy Bolmar): Okay. And what about the demonstration?

Connie Leonard: (Cathy). This is Connie Leonard. I was the (product) officer during the RAC demonstration. You received letters at the Tennessee facility?

(Cathy Bolmar): No. It was one of our others. I'm sorry. I'm an Executive Vice President.

Connie Leonard: I'm sorry. Okay. So you have a facility and one of the demonstration states that never has heard about the findings. If you would actually send us an email at the rac@cms.hhs.gov email address with some specifics, we can find out the status of those claims for you.

(Cathy Bolmar): That would be terrific. Thank you. But it'll be 60 days going forward.

Connie Leonard: Yes.

(Cathy Bolmar): Great. Thanks very much.

Operator: Thank you. The next question's from (Ginger Redding) from California. Your line is now open. (Ginger Redding) from California, your line is now open.

(Ginger Redding): I'm sorry. I was on mute. Yes, this is (Ginger Redding) from UCSF Medical Center. I work in compliance. I have a couple related questions. First when we get a (unintelligible) advice with the code N432, will that be specific to a claim or will that just name and amount that's being requested?

Terry Lew: This is Terry Lew. I'm also a colleague. The N432 code should be accompanied by a - that'll go into detail on why that specific claim was adjusted by the RAC.

(Ginger Redding): So we'll know which claim that applies to.

Terry Lew: Correct.

(Ginger Redding): Okay. Will we get a letter back even if there were no findings?

Ebony Brandon: Yes.

(Ginger Redding): So we will get a letter for each request that's claimed.

Ebony Brandon: Correct.

(Ginger Redding): And that will have details of the findings if there are findings.

Ebony Brandon: Yes.

(Ginger Redding): Okay. And if it's past 60 days, will we then close that case? Can we then say that...

((Crosstalk))

Ebony Brandon: No.

(Ginger Redding): ...not able to have any findings?

((Crosstalk))

Ebony Brandon: No. They're required to notify you within 60 days. If it goes past 60 days, you should first reach out to the RAC.

(Ginger Redding): Okay.

Ebony Brandon: Contact them to find out exactly what's the status and, you know, but you should receive notification within 60 days.

Melanie Combs-Dyer: This is Melanie again. The Recovery Audit Contractor on occasion may need to go beyond that 60-day window. But if they do, they have to come in to CMS and ask for permission and once we give them the thumbs up and give them a timeframe by which they have to complete that review, they would have to get back to you and they would have to say CMS has granted us an extension. We now have until day 70.

So you will know if there is an extension that they have beyond that 60 day mark. And like Ebony said, if for whatever reason you don't hear anything back, it means that there is some kind of a fluke in the system and you do need to reach out to the RAC and let them know.

(Ginger Redding): Okay. Thank you.

Operator: Thank you. The next question's from (Patty Bloomberg) from California. Your line is now open.

(Patty Bloomberg): I had a simple question that we wanted to find out if there were any written documents that spell the names of the people speaking from CMS on these phone conferences.

Ebony Brandon: No, but I can give you the spelling right now if you want that.

(Patty Bloomberg): Lieutenant Gia (Ray), what is that?

Gia Lawrence: Gia, G-I-A, Lawrence, L-A-W-R-E-N-C-E.

(Patty Bloomberg): So it's Gia Lawrence, not Lieutenant, right.

Gia Lawrence: Lieutenant Gia Lawrence.

(Patty Bloomberg): Oh it is Lieutenant. Thank you very much.

Gia Lawrence: You're welcome.

(Patty Bloomberg): And then Ebony (Fine)...

Ebony Brandon: It's Ebony, E-B-O-N-Y, Brandon, B-R-A-N-D-O-N.

(Patty Bloomberg): And (George Bell), that's correct.

Ebony Brandon: Mills, M-I-L-L-S.

(Patty Bloomberg): Mills. Thank you.

Ebony Brandon: You're welcome.

(Patty Bloomberg): And then the other - the other individuals - it's been so nice to hear Melanie Combs (Ryder). Her name comes out loud and clear. The other people speaking and answering questions...

((Crosstalk))

Melanie Combs-Dyer: Yes, this is Melanie Combs-Dyer. It's M-E-L-A-N-I-E. And my last name is C-O-M as in Mary, B as in boy S hyphen D as in dog, Y-E-R.

(Patty Bloomberg): O-R.

Melanie Combs-Dyer: E-R.

(Patty Bloomberg): Okay. Thank you.

Melanie Combs Dyer: D-Y-E-R.

(Patty Bloomberg): Great. Okay. And the other speakers that followed you Melanie that were sharing some of the costs.

Terry Lew: This is Terry Lew. T-E-R-R-Y, last name L-E-W. I'm also a Lieutenant in the Commission Corp of U.S. Public Health Service.

(Patty Bloomberg): Oh, thank you.

Connie Leonard: And lastly Connie Leonard, C-O-N-N-I-E L-E-O-N-A-R-D.

(Patty Bloomberg): L-E-O-N-A-R-D.

((Crosstalk))

(Patty Bloomberg): Thank you very much.

Operator: Thank you. The next question's from (Devra Bowers) from North Carolina. Your line is now open.

(Devra Bowers): Hi. Thank you and thanks again for holding this particular teleconference. I have two questions first of which I'm asking this from the standpoint of a pharmacy who is a Part B as in boy (DNE) provider. What is going to be the main difference between a CERT, which we have seen like in jurisdiction (D meridian) and a RAC letter that we would receive and would that come to a corporate office or would that come to the individual pharmacy?

Melanie Combs Dyer: This is Melanie. And it will come to whoever is doing the billing. It's the same as it is in your regular Medicare program. Whoever your FI reaches out to or whoever your carrier reaches out to, whoever the CERT contractor reaches out to, that'll be the same place that the RAC will go to.

Like Ebony said earlier, you can customize that address if you want that to go to a particular individual in a particular department in the pharmacy but generally speaking they will be using the same address as your FI has or the CERT contractor has.

(Devra Bowers): Okay. And is that something that is going to be very product specific that we have found in the different jurisdictions that it would be say diabetic test strips or is this just all claims and any items that have been billed?

Melanie Combs Dyer: Yeah. Anything that has been billed to Medicare.

(Devra Bowers): Perfect. Well thanks for all your help. Appreciate it.

Melanie Combs Dyer: You're welcome.

Operator: Thank you. The next question's from (Connie Shultz) from (Morgan Berry). Your line is now open. (Connie Shultz) your line is now open. Your phone may be on mute. There is currently no response from her line. We'll go to the next person.

(Diana Ryan) from Arizona, your line is now open.

(Bob Ryan): Hi. This is (Diane's) partner, (Bob Ryan) and I had a couple of questions. I'll make them brief. First question I had is I understand there's up to five levels of appeal following a determination (whether) by the RAC and in the opening comments there was a mention that if the provider makes a timely appeal that that would be (way) recoupment or extend any obligation to repay during the appeal process. Do I understand that correctly?

Ebony Brandon: That's correct.

(Bob Ryan): And is that an interpretation CMS has given to the rule or is there actually a statutory or regulatory reference you could give me on that? In the (unintelligible) about RACs I've been told by the speakers just the opposite so I view this as a favorable position for a provider but I'd like to be able to reference that somewhere.

Connie Leonard: CMS - this is Connie Leonard. CMS is currently implementing Section 935 of the Medicare Modernization Act. What that

section does is it has requirements in there for CMS to staff recoupment.

There is a proposed rule currently outstanding in that and a final rule will be published in the very near future that details the requirements that (unintelligible) and CMS will staff.

That interpretation is - of 935 that CMS intends to implement is that we will stop recoupment at the first and possibly second level of recoupment. It has nothing to do with the Recovery Audit Contractor program. That is all of Medicare's recoupment process is changing because of this Section 935.

I do not know the Federal Register number or the rule number right off the top of my head but if you want to send an email into this CMS (Bob), we can certainly get that for you.

(Bob Ryan): Oh, that'd be great. Could I ask my next question?

Connie Leonard: Sure.

(Bob Ryan): Okay. The next question I had was whether or not a RAC has the authority to settle on individual claims.

((Crosstalk))

(Bob Ryan): Okay.

Connie Leonard: The RAC does not have the ability to settle. If they do get a settlement proposal, they have to send that to CMS.

(Bob Ryan): Okay. And the last question I have is a hypothetical. If a provider were to hire a consultant to come in on a I'm going to say a pre-RAC audit and the consultant's identify what might constitute a pattern of omissions or errors in a billing process by the provider, does the - does the consultant have any responsibilities to inform CMS or is that still up to the provider?

Melanie Combs Dyer: This is Melanie and I think I'm going to defer on that question. We have a benefit integrity group, our area that handles fraud and abuse and I believe that they may be better able to answer that question.

If you again send that question to rac@cms.hhs.gov, we can forward that on to the right people and make sure that our folks down in the fraud unit either work with law enforcement or get you the right citation for the manual for how that would work.

(Bob Ryan): Okay. And could you give me one last time that email information.

Melanie Combs Dyer: It's rac, R-A-C...

(Bob Ryan): Yeah.

Melanie Combs Dyer: ...at cms.hhs.gov, G-O-V.

(Bob Ryan): Oh great. Okay. Very good. Thank you.

Operator: Thank you. The next question is from (Lotta Hanson) from California. Your line is now open.

(Lotta Hanson): Hi there. How are you? I'm calling in regards to California. What's the phone number for the RAC office and will it be the only RAC in Northern California?

((Crosstalk))

(Lotta Hanson): No, this is the first one. What would be that phone number?

Ebony Brandon: For the RAC. We don't hardly - there's been a pause in RAC activity. Once that pause is lifted, the information, contact information for the RAC will be provided on the CMS Website.

(Lotta Hanson): So when do you expect that information? When can we expect that information on the Website?

Melanie Combs Dyer: This is Melanie. And I think I'll repeat what George Mills said earlier. We anticipate that the General Accounting Office will issue their decision sometime before February of '09. So somewhere between tomorrow and middle of February.

(Lotta Hanson): Okay. Wow. Okay. You said earlier in the conference here that the refunds will be paid back to the RAC via five ways. Can you repeat those? One of them used to be with CMS that they would deduct it from the checks, the electronic checks that they send. Is that still going to be the situation going forward?

Gia Lawrence: Yes. This is Lieutenant Lawrence. Let me - let me review the options again. The first one is to allow recoupment. The second one is you can pay by check.

(Lotta Hanson): Hold on. I'm writing it down.

Gia Lawrence: Okay.

(Lotta Hanson): Next.

Gia Lawrence: Okay. Do you have the first on, allow recoupment?

(Lotta Hanson): (Unintelligible).

Gia Lawrence: I'm sorry.

(Lotta Hanson): Yes, I do.

Gia Lawrence: Okay. The second option is to pay by check.

(Lotta Hanson): (Unintelligible).

Gia Lawrence: Okay. The third option is to stop recoupment by appealing.

(Lotta Hanson): Hold on. Okay.

Gia Lawrence: Okay and the last option is to sign up for an extended repayment plan.

(Lotta Hanson): Now is there a special form for the appeal?

Ebony Brandon: Once - the RAC will send a letter to you that will list your appeal rights and what next steps you should take.

(Lotta Hanson): Right, but is there a form? Is there going to be a specific for on your Website?

Ebony Brandon: No.

(Lotta Hanson): No. Okay. So it'll just be in writing. So I guess, lets see. What's the Website for the RAC again? Can you give me that address?

Ebony Brandon: Yes, www.cms.hhs.gov/rac.

(Lotta Hanson): Forward slash or back slash?

Ebony Brandon: Forward.

(Lotta Hanson): Okay.

Melanie Combs Dyer: This is Melanie. I just wanted to add I am not sure what the requirements are for filing an appeal. I believe like Ebony that there is no special form but I'm not sure. I would again refer you to whatever letter you get from the RAC. It'll be just like the normal appeal process. However you file an appeal now you will file an appeal in the future.

((Crosstalk))

Connie Leonard: ...your FIs or carriers Website extremely helpful in their appeal process. Some of them do use forms and they would be out there and you would be able to easily download them.

(Lotta Hanson): One last question. On the N432 code, is there going to be a list that I can pull off of your site currently that will have all the codes that correlate to whatever - kind of funny - the N432 code, is it the name of a list or is that the specific code that means

something. I mean I don't quite - is that - that means really you need that money back. What does it man exactly?

Terry Lew: Sure. This is Terry Lew again. N432 is one of, I'm going to go out on a limb and say about 200 of what they call remittance advice remark codes. Codes are developed by something called the Uniform Billing Committee and are actually published by a company called the Washington Publishing Company.

And I do not remember their Website off the top of my head. I believe it's wpc-edi.com. If you Google Washington Publishing Company and codes, you should be able to pull it up or use your favorite search engine. Not that we can endorse anything. But if you look up that company, they are the official distributor of the code sets. You can download the codes or you can actually purchase them as well if you'd like.

Melanie Combs Dyer: And these are the same codes that our regular carriers and FIs and MACs use on the remittance advices that they send to you. Terry has just created a new one that will let people know when an action is taken because of a RAC.

One thing that we learned during the demonstration is that there were providers who could see that there were, you know, that they had a long list of denials that had come through form their carrier or FI but they couldn't tell which ones were because of the regular carrier and FI had identified the problem or which ones were because a RAC had identified the problem.

So we have created N432, the remark code, that Terry just referred to and it's called adjustments based on recovery audit.

And that will let the provider know that that particular line has been adjusted because of recover audit contractor finding.

(Lotta Hanson): Got you. That makes sense. So, all right. Good. Well thank you for the info and I hope you have a great day.

Ebony Hanson: Thanks.

Operator: Thank you. The next question's from (Marge Johnson) from Texas. Your line is now open.

(Marge Johnson): Yeah. I don't understand why I'm always (unintelligible).

Ebony Brandon: I'm sorry. We can't hear you. Can you get closer to your phone please?

Operator: (Marge Johnson) from Texas. Your line is now open.

(Marge Johnson): Our question's already been answered. Thank you.

Operator: Thank you. The next question's from (Tamara Bronson) from Pennsylvania. Your line is now open. (Tamara Bronson).

(Tamara Bronson): Yeah. Can you explain to me exactly what the automatic process is and how it happens?

Ebony Brandon: Sure. The automated review process that they perform their data monitoring techniques. They'll, you know, like I said look through the OIG (their) reports, propose a new issue for review to CMS. CMS approves that. Then they use the data, the claims data, that they have from CMS and run it through the system to

identify, you know, what providers if any have that issue. And if they do find an issue, like I said, you'll receive a demand letter from the RAC stating that this is the amount that's due CMS.

(Tamara Bronson): So you're comparing us to other providers.

Ebony Brandon: No.

Melanie Combs Dyer: This is Melanie. A couple of examples of automated reviews would be things like duplicate claims. If you submitted two claims for the same services for the same (bene) for the same date and your carrier paid both of them, that second one represents an improper payment. And if the Recovery Audit Contractor finds it, they will send you a demand letter and ask for that money back.

(Tamara Bronson): Okay.

Melanie Combs Dyer: A second example that we saw during the RAC demonstration was a situation where the provider performed three procedures during the same operative session and the Medicare payment rules say that a provider is due 100% of the fee schedule amount for the first one and 50% for the second one and something like 255 for the third one.

But unfortunately the carrier had some incorrect algorithms in their pricing schedule and they paid 100%, 100% and 100%. That claim represents an improper payment. And when the Recovery Audit Contractor found it, they wrote a demand letter to the provider and asked for the money back.

Those are the kinds of things that a Recovery Audit Contractor can call an improper payment and issue a demand letter on without having to order the medical record.

(Tamara Bronson): Got you. Okay. Thank you.

Operator: Thank you. The next question's from (Carol Eaton) from California. Your line is now open.

(Carol Eaton): Yes. Is there going to be an electronic list that we can access through the RAC auditors that will give us the records that have been requested, the status of received, the response? Is that something you guys are looking at? Because we have many, many duplicate requests for records.

Ebony Brandon: (Carol), the claim status Website is a requirement for the RAC but they don't have to have that in place until 2010. Some may decide to get that in place as soon as possible but that claim status Website will allow you to go in and review the status of your claims. If the record was received, where it is in the process now. But until then you are able to call the RAC or email the RAC to find out the status.

(Carol Eaton): Okay. And then my second question was when we have the first appeal, those here in California were an automatic denial. There was like, we could tell, it was an automatic denial. Do you know if that' something that will be any different?

Connie Leonard: Well the appeal entity at the first level is the FI, the carrier or the e-claim processing contractor and they should not be doing automatic denials. They should be reviewing the case on its

merits making a decision. So if certainly you come up with issues in a national program where you think that there may be situations of automatic denials, we would want you to alert CMS so that we can look into the issue.

(Carol Eaton): Okay. And then are things going to be any different for our rehab?

Connie Leonard: Well the review of inpatient rehabilitation facilities would again have to be approved by CMS and the new issue review process. So those were to come in here. We would have reviewed their methodology and then make a determination if they could move forward or not. So yes, we don't think that we'll see the same types of issues that we did in some (unintelligible) demonstration because of this new issue review process.

(Carol Eaton): Okay. And then I understood what this - that all of the review contractors will be on the same playing field. They will have the same information. They will be reviewing pretty much the same thing. It's not going to be every state, you know, doing their own thing.

Connie Leonard: That is correct. The demonstration - the purpose of the demonstration was to determine if the (effective) contractors could do this type of work in Medicare. And they've proved that they could and that it could be - that it could be beneficial for Medicare.

So in going forward, if there is an issue in one region, CMS will be sharing that with all of the regions as well as all the issues

being posted to the RAC list. So I would imagine that each of the RACs will view everyone else's - everyone else's Web page.

So we certainly think that there is not going to be isolated areas to review just in one region or one state unless it really is an issue specific to that state. It is possible there could be an issue in one state or one region that isn't in the others. So we expect that these things will be more shared and more equally distributed (this time).

(Carol Eaton): Okay. And my very last question if you'll allow me is if a - I understand the reviewers will be nurses, nurse reviewing, but will there be any physicians involved if it gets into something that is specialty like (HBO), radiation oncology, you know, will there be physicians involved at all.

Connie Leonard: All of the RACs have to have a medical director full time so that they can utilize them if they get into situations that they feel need a physician review. In addition, most of the RACs have consultants, physician consultants that they can turn to if it is a specialty issue where the medical director doesn't have experience.

(Carol Eaton): Okay. Thank you.

Operator: Thank you. The next question's from (Carletta Voxnip) from South Dakota. Your line is now open. (Carletta)...

(Carletta Voxnip): No, this is (down) at Rapid City. I'd like to know what the background of these nurse reviewers is.

Ebony Brandon: Like I said earlier, they're currently (a cause), you know, with the RAC program. Once the RACs are in place, they are required to give that information to providers upon request. Their credentials of (that).

(Carletta Voxnip): So they're not specifically - I mean people that - they're just general nurses or they're people that have a background in specific hospital issues and levels of care and that type of thing.

Melanie Combs Dyer: This is Melanie. And all of our Recovery Audit Contractors will have to pay back their contingency fee if they lose on appeal. And so they have a pretty big incentive to make sure that the decisions that they're making on the claims are accurate right from the beginning.

We would expect that they would be hiring nurse reviewers and certified coders who are experienced at reviewing the claims that they are given. So nurses who have inpatient hospital experience would likely be reviewing inpatient hospital claims. And coding experts who are certified physician coders would be given claims to review that has a physician coding problem. That's what we would expect the recovery audit contracts to be using.

(Carletta Voxnip): I have one more question if that's all right. Yes, I'd just like to clarify something - yesterday at the - on the conference call they said that if there was a positive result from the - from the letter in regards to the appeal that you would not be receiving a letter. And today I thought you said that you would receive a letter for the positive and the negative from the RAC in regards to the outcome of the appeal.

Ebony Brandon: Not in regards to the outcome of the appeal; for the rack review. You will receive a letter giving you the details or review results of the RAC review, not the appeal.

Whatever appeal process you have now with your, you know, FI, carrier or MAC will be the same for the RAC.

(Carletta Voxnnip): Okay. Thank you.

Ebony Brandon: You're welcome.

Operator: Thank you. The next questions' from (Virgie Levado) from California. Your line is now open.

(Virgie Levado): Hi. My question would be on those inpatients; either one-day inpatient say the RAC determination say should be outpatient. In the old RAC we were able to re-bill it as an outpatient or observation. Is that the same thing in the new RAC?

Ebony Brandon: No. You will not be able to re-bill in the permanent program unless you're still under the timely requirement deadline. But other than that, no you would not be able to re-bill.

(Virgie Levado): Are we able to re-bill the Part B ancillary charges?

Ebony Brandon: No. Unless you're within - whatever the normal rules are...

((Crosstalk))

Melanie Combs Dyer: Ebony and I are not experts in claims processing rules. But whatever you're allowed to do today in your regular carrier, FI process, you will be allowed to do in the future for a RAC denial.

(Virgie Levado): So that means we could just - if we are still in the timeframe, we're still able to do the ancillary charges for those.

Ebony Brandon: Correct.

Melanie Combs Dyer: Yeah. If you're allowed to do it today with your regular FI, then you'll be allowed to do it with a RAC initiated denial.

(Virgie Levado): All right. Thank you.

Operator: Thank you. The next question's from (Jerry Byrd) from Arizona. Your line is now open.

(Jerry Byrd): Yes. My name is (Jerry Byrd). I'm from Scottsdale, Arizona. Just had a question about the interest rate. I understand how it's set, you know, using the, you know, the funds value and the consumer rate. My question was though based on today's information that the interest rate would be 11.25%.

You know, in talking with some of the, you know, our finance people, they were saying well that seems too high. That must be an annualized percentage rate. And I did not think that it was an annualized percentage rate. It was my understanding that that's applied on a monthly basis. Is that correct or incorrect?

Ebony Brandon: Whatever the normal process is, that would apply for RAC. That's for Medicare. That's not a RAC issue. So whatever the normal process is, that would apply to RAC as well.

Connie Leonard: If you want to send that question in to our rac@cms.hhs.gov's mailbox, we can get that question answered for you from the area that does the interest calculations. But I'm just not sure of the answer if it's annualized or not.

(Jerry Byrd): Okay. And then one more question along those same - along those same lines. If we - if we, you know, lose on appeal, you know, 30, 60, 45, 180 days later, you know, we would pay interest. If we win on appeal, you know, would it not seem to hold true that the RAC contractor should pay interest on the contingency amount? And I don't think I've seen that anywhere.

Connie Leonard: If the RAC contractors lose at any level of appeal, they have to repay the contingency on that. But if the provider never paid anything and they hadn't received their contingency payment yet - now if the provider has already paid because it wanted to avoid any potential interest assessments, then you're correct, the RAC would not be charged interest on that contingency fee. They would only just have to repay CMS that fee.

(Jerry Byrd): Yes. What I'm saying is I think what's good for the goose is good for the gander. I would think that they should pay interest if they lose.

((Crosstalk))

(Jerry Byrd): I have to pay interest if I lose.

Connie Leonard: I understand your comment. We'll certainly consider that as we make provisions to the statement of work.

(Jerry Byrd): Okay. Thank you.

Operator: Thank you. The next question's from (Debbie Miller) from Maine. Your line is now open.

(Debbie Miller): Hi. I'm (Debbie Miller) from the Maine Center for Cancer Medicine. I know you stated that in 2010 there'll be a Website that we can go on and customize our address and who the letter should go to. But prior to that when the RACs or the final determination of the RACs are made, will we be able to let them know who the letter should go to?

Ebony Brandon: (Debbie), yes you will. You will have a telephone number, email address. You have contact information for the RAC and we encourage you to reach out to them to give them the name and the address for where you would like those requests to go to.

(Debbie Miller): Okay. Thank you.

Ebony Brandon: You're welcome.

Operator: Thank you. The next question's from (Linda Wheaton) from South Carolina. Your line is now open.

(Linda Wheaton): Yes, you answered our question initially. Did you have something else? That was all. Thank you.

Operator: Thank you. The next question is from (Sue Kerney) from Florida. Your line is now open.

(Sue Kerney): Yes, I was just wondering. I know that at this moment that everything is on hold. But we also had a RAC back in early August. Will we still be able to find out if I go online and email them what the status of that is or do we need to wait until February when everything - the status is active again?

Melanie Combs Dyer: (Sue), what state are you in?

(Sue Kerney): Florida.

Melanie Combs Dyer: And you believe that your recovery audit - the demonstration Recovery Audit Contractor sent you a demand letter in August.

(Sue Kerney): No. No. No. We went through the audit in August. They came on site and we had pulled, you know, dozens of charts. We've never heard anything back from them.

Melanie Combs Dyer: Our Recovery Audit Contractor in Florida left the program. All of our demonstration RACs left the program in March of 2008. So if someone was auditing your records in August of 2008, it was not a Recovery Audit Contractor. Not a Medicare Recovery Audit Contractor. It may have been Aetna's Recovery Audit Contractor or somebody else's Recovery Audit Contractor but it was not a Medicare Recovery Audit Contractor.

(Sue Kerney): Okay. It had CMS up in the corner. Okay. Well I'm glad you told me that. All right.

Melanie Combs Dyer: If it was - if you're sure it was someone associated with CMS, it's possible that it was your Program Safeguard Contractor or the Zone Program Integrity Contractor, one of the fraud fighters. But it certainly was not a Recovery Audit Contractor.

(Sue Kerney): It was probably Integrity. You're right. Okay. Great. All right. Thank you very much. I will contact them directly.

Operator: Thank you. The next question's from (Kelly Alviston) from Utah. Your line is now open.

(Kelly Alviston): I have two questions for you. The first is the DME MACs currently do their own post and prepay audit reviews. Is this process going to replace that at all? Are they going to work in conjunction? It's possible I guess for some of our claims to be reviewed under both agencies at the same time.

Ebony Brandon: No. The RACs will not replace the DME MAC and you will not have duplicate reviews. We have a data warehouse where if the - your current MAC is reviewing a claim or has reviewed a claim, it will be suppressed and the RAC will not be able to review that claim as well.

(Kelly Alviston): Okay. Great. And will the - will the results of that type of review be sent in to trigger RAC reviews as well.

Ebony Brandon: I'm not sure.

Melanie Combs Dyer: This is Melanie. And we have been meeting with the representatives from the MACs as well as the Program Safeguard Contractors and (VPICs) to talk about a process whereby the MACs and the fraud fighters could make referrals to the Recovery Audit Contractors in those cases where no fraud has been found but there is some potential for improper payments that exist.

And so it is possible that there could be referrals that way. There could also be referrals from the RAC to the fraud fighters. So the referrals could go both ways depending on what's out.

(Kelly Alviston): Okay. My last question and I apologize if this was already hit in the first few minutes because I came in a little bit late. But how does - what are the expectations or the - how are the standard steps for the RAC to be able to maintain their contract?

Is there a certain percentage of claims that they audit that the need to have recoupment on? Is there an expectation in amounts that they're supposed to recoup? I understand they only get paid when they recoup items. But what is the expectation for them to fill their contract from CMS' side?

Connie Leonard: The performance measures that CMS has (at line) for the RACs actually do not - are not centered around their collection. They're much more centered around their customer service and are they doing things that they need to do from an administrative perspective. So there is no quota per se for the RAC that they have to meet in order to maintain their contract.

(Kelly Alviston): And is CMS going to do any type of auditing or governing of the RACs or are they just going to wait to see if the (providers) have specific complaints on RACs?

Connie Leonard: No. CMS will be doing its own internal auditing and review and performance metrics as well as having a validation contractor review a sample of claims each month to determine an accuracy rate that CMS will publish once a year to determine the accuracy of the identifications.

(Kelly Alviston): All right. Thank you.

Operator: Thank you. The next question's from (David Smith) from Pennsylvania. Your line is now open. (David Smith) from Pennsylvania, you line is now open. Your phone may be on mute sir.

(David Smith): I'm sorry. I'm there. I'm there. This is (David Smith) from the rainy Pocono Mountains. I hope your weather is better down there.

I have a couple of questions please if I may. Am I still connected?

((Crosstalk))

Connie Leonard: Yes.

Ebony Brandon: Go ahead.

(David Smith): Okay. Good. I've listened to three different Medicare presentations on the RAC within the past two days and our FI tells us the requests are based upon tax ID numbers and there seem to be some confusion with the other requests. Are you requesting based upon tax ID numbers are MPIs, NPIs?

Terry Lew: This is Terry again. Medical record requests limits will be based on NPIs. We're still trying to determine exactly how that's going to work as far as multi site organizations and multiple MDI organizations go. We haven't quite finalized those yet.

Tax ID numbers may ultimate be an element of our plan but at this point that's not going to be the primary determinant of how many records each site will be requested to supply.

(David Smith): Now when they request the charts, are they also going to be requesting copies of the bills?

Terry Lew: The RACs will be supplied with claim data directly from CMS so they should not be requesting copies of the bills.

(David Smith): Well I didn't think so either but the requests that I'm getting currently from CMS from our MAC do include a request for the bill which I think is very odd, so.

Melanie Combs Dyer: I have - this is Melanie and I'm not sure why your Medicare administrative contractor would be asking you for a copy of the bill. But the Recovery Audit Contractors will not be asking for the claims. They have the claim data. They know how much - they know what codes you submitted on the claim and they know how much the carrier or the FI paid. All they need is

the medical records so that they can complete that review and make a determination about whether any improper payments were made.

(David Smith): I see. That's very helpful. Now this has probably been covered but I forgot. Are you going to be paying for medical record copies?

Ebony Brandon: Only for inpatient hospitals.

(David Smith): There will be payment because the - yeah the Medicare administrator contractors claim no, they don't have to pay for copies.

Ebony Brandon: Correct. The RAC will pay for inpatient hospital medical records.

(David Smith): Well that's good. And could I sort of answer another person's question as far as review of the RACs or at least make a comment? The OIG work plan includes that they will be looking at the RAC audits also.

((Crosstalk))

Connie Leonard: That's correct. Thank you.

(David Smith): Okay. And the email address that they - you are giving out as far as requesting information.

Ebony Brandon: It's rac@cms...

(David Smith): No, I already know it. I sent an email quite a while ago and I never got an answer. But I got an answer when I called the other day. So I got my answer eventually. Well thank you very much.

Ebony Brandon: You're welcome.

(David Smith): Bye.

Operator: Thank you. The next question's from (Cathy Dunce) from Tennessee. Your line is now open.

(Cathy Dunce): Yes. Could you answer the question about the limiting the number of claims as a DME provider?

Ebony Brandon: You mean the limit on the number of medical records that can be requested...

(Cathy Dunce): Yes.

Ebony Brandon: ...for a complex review?

(Cathy Dunce): Yes.

Terry Lew: Certainly. The record for or the limit for Part B billers, non-physician Part B billers, is going to be 1% of your average monthly Medicare paid services per 45 days. Does that answer your question or did I miss the gist of it?

(Cathy Dunce): No. That's it.

Terry Lew: Okay. Great. Thank you.

(Cathy Dunce): And then I had a second question but you already answered that one. So thank you.

Terry Lew: Certainly.

Operator: Thank you. The next question's from (Sean Wassingame) from Maryland.. Your line is now open.

(Sean Wassingame): Yes, I wanted to check - what was the Website where we could go see the list of the I guess equipment or services that's up for automated review?

Ebony Brandon: The RAC will be required to post those new issues to their Website. Right now there's a pause and we don't have any RACs in place. Once the RACs are up and running, their contact information in addition to the Website will be posted and you'll be able to review that list on the RAC Website.

(Sean Wassingame): Okay. All right. Thank you.

Ebony Brandon: You're welcome.

Operator: Thank you. The next question's from (John Wright) from Arizona. Your line is now open.

(John Wright): I thin my question was answered earlier but I just want to clarify. The automated reviews will be just more obvious billing, coding issues that do not require documentation to determine like a level of service or something like that. Is that correct?

Ebony Brandon: Correct.

(John Wright): Okay. Thank you.

Operator: Thank you. The next question is from (Julia Ward) from Illinois. Your line is now open.

(Julia Ward): My question was already answered. Thank you.

Operator: Thank you. The next question's from (Tina Cleveland) from New Mexico. Your line is now open.

(Tina Cleveland): Hi. Good afternoon. In the presentation you indicated that the RACs will be using NCDs, LCDs and CMS manuals. Is there any indication as to the prioritization of those or the level like which - is it which benefits the RAC program most or is it, you know, in a hierarchy? One overrules the other?

Melanie Combs Dyer: This is Melanie. And NCDs, the national coverage determinations always take precedence followed by the local coverage determinations and the CMS manual. And in theory they all - none of them conflict with each other and they all blend together nicely and our Recovery Audit Contractors will abide by them all.

They cannot make up policies on their own although they can review claims even in the absence of an NCD and LCD or a manual provision. We call those individual claim determinations and they would base those on their clinical judgment and their knowledge of the way that medicine works.

(Tina Cleveland): So are the RACs familiar with the region they're auditing because when - with the redistribution of the jurisdictions, you know, we were receiving RAC review from a RAC that was familiar with a different region than the one we were in and we had to prove that our local coverage determination was the one we were following.

((Crosstalk))

Melanie Combs Dyer: No, the RACs will - so the RAC - this is Melanie. The RACs have to use the local coverage determination that is in place in the jurisdiction where the service was provided on the date of service.

And we understand that there may be a number of changes to local coverage determinations as carriers and FIs leave the program and Medicare administrative contractor come into the program. And you're right, it is difficult for anybody to keep track of all the various policies and the many changes to them.

But our Recovery Audit Contractors are required to abide by all the LCDs that were in affect in the jurisdiction at the time that the service was provided.

(Tina Cleveland): Okay. You answered my question basically the hierarchy is in the manner which you mentioned, NCD, then LCD, then CMS manual.

Melanie Combs Dyer: Right.

(Tina Cleveland): Okay. Thank you.

Operator: Thank you. The next question's from (Susan Keller) from North Carolina. Your line is now open.

(Susan Keller): Hi. Thank you. I've got two questions. And that is one is if there is a disagreement on a clinical aspect, can we request a physician review? If we have a physician who says no I don't agree with this nurse provider and we feel that we're not getting the answer that makes sense to us, can we actually request that we have a physician review?

Ebony Brandon: You can request to speak with the physician, the RAC CMD, and then they will review the issue and, you know, talk to the physician and give you an answer.

Melanie Combs Dyer: But you cannot put in a request that a physician review every claim.

Ebony Brandon: Correct.

Melanie Combs Dyer: The way that the Recovery Audit Contractors are set up is very similar to the way our carriers and our FIs and our MACs are set up; that is the review are predominantly performed by nurses and certified coders and physicians can get involved if the nurse reviewer or the certified coder requests the physician to get involved because the case is so complicated that it requires the actual physician to get involved.

But normally speaking the reviews will not involve physician review although like Ebony said, you can have a discussion with

the medical director after you have received the denial letter from the Recovery Audit Contractor.

(Susan Keller): And I had just another slight question. When they perform an audit on Part B services and they're using an audit tool, do they use the CMS audit tool and are they required to use the 95 or 97 which is the most beneficial to the physician as CMS does?

Melanie Combs Dyer: This is Melanie again. And yes, the Recovery Audit Contractors have to follow the rules in place for all Medicare contractors for physician evaluation and management services, E&M services and those rules currently state that a reviewer will review the claim under the 95 guidelines and then review the claim under the 97 guidelines and abide by whichever one is most advantageous to the provider.

(Susan Keller): If we have an established audit plan in place for instance and this is how we've for years established under 95, this is how many for instance points that we use for exam. You know, we've divided it two to four to five to seven and so on. Does that hold any measure of importance to that RAC auditor?

Melanie Combs Dyer: Are you a physician's office or are you an outpatient hospital?

(Susan Keller): Physician.

Melanie Combs Dyer: It will be whatever the 95 and 97 guidelines are at that - that's what the RAC will use and I can't answer in any more detail than that. You would have to - if you have a question

about how to interpret a particular part of the 95 or 97 guidelines...

(Susan Keller): No I don't. No. The one other thing is that you - you were talking about when they do the automated - when they do the automated pull from the data mining that we do not know - you were talking about being able to go in and look at that but apparently currently we won't be able to do that for some time and that we do not know until we actually get that denial.

If we were to disagree with that denial - when we look at that claim and we disagree with that denial, I know that the timeframe for review is there but if we disagreed with that N342 once we see that denial come through, what's the timeframe for that? I missed that.

Ebony Brandon: From the date of that demand letter you can pick up the phone and call the RAC for the discussion period.

(Susan Keller): But that wouldn't be a demand letter. That would just simply be the denial code for...

Ebony Brandon: You'll get - but you'll get a demand letter in addition to your remittance advice.

(Susan Keller): Oh, I misunderstood. I thought you said that we wouldn't receive anything that we would just simply have that denial code.

Ebony Brandon: No, I'm sorry. You will get...

(Susan Keller): Oh, okay.

Ebony Brandon: Yeah. You'll see it on your remittance advice.

(Susan Keller): Wonderful. I was - I was going oh my gosh. Thank you so much for your help.

Ebony Brandon: You're welcome.

(Susan Keller): Have a good day.

Ebony Brandon: You too.

Operator: Thank you. The next question is from (Crystal Thompson) from Tennessee. Your line is now open.

(Crystal Thompson): Yes. I had a couple of questions. When - if the RAC goes over their 60-day time limit in reviewing your claim, will you be notified in writing?

Ebony Brandon: Yes.

(Crystal Thompson): Okay. Second question. The Program Safeguard Contractor that's in place now with our FI, will the RAC be in addition to that doing post payment and prepayment which is kind of what we're doing now?

Ebony Brandon: The RACs only do post payment review.

(Crystal Thompson): Okay. So the Program Safeguard Contractor will still be in place in addition to the RAC.

Ebony Brandon: Yes.

(Crystal Thompson): Okay. My last question is it seems like the RAC is (incentivized) for the amount of money that they recoup. Is there penalties for them for recouping incorrect money such as money for the provider for, you know, injury?

Melanie Combs Dyer: The Recovery Audit Contractors have to repay their contingency if they lose at any level of appeal.

(Crystal Thompson): Okay. But what about payment to the physicians or money they're out for additional staff, copying of records, postage, anything like that?

Melanie Combs Dyer: Nothing like that.

Ebony Brandon: The same appeal system that's currently in place will be in place with the RAC.

Melanie Combs Dyer: Correct.

(Crystal Thompson): I think that's all I had. Thank you.

Operator: Thank you. The next question's from (David Connelly) from D.C.. Your line is now open.

(David Connelly): Am I correct that if the RAC misses the 60 day review time period without a CMS extension the review continues? Or in other words there really is no penalty on the RAC for missing that 60-day period.

Ebony Brandon: The RACs are required to have those reviews completed within 60 days. There are rare occasions where they may need more time and they have to come to CMS for approval on those cases.

(David Connelly): But what if they don't.

Ebony Brandon: We would handle those on a case by case basis.

(David Connelly): Oh, okay. Thank you.

Operator: Thank you. The next question is from (Kim Lague) from Tennessee. Your line is now open. Okay, she has gone out of queue. The next question is from (Sheila Gadell) from Wisconsin.

(Sheila Gadell): Hi. I have a question on the medical record limits you noted the complex review medical record limit. So does that infer that automated reviews can occur in addition to those complex reviews...

Ebony Brandon: Yes.

(Sheila Gadell): ...during that 45-day period of time.

Ebony Brandon: Yes.

(Sheila Gadell): Okay. My second question is (unintelligible) critical access hospitals are not paid on the DRG or APC basis. Is there any clue as to how the recoupment will take place for those critical access hospitals?

Ebony Brandon: Yes. For - any adjustments will be reflected on the final PS&R and if the cost report has already had a final settlement, the amount will be demanded and then offset against future claims if it's not paid in full by the provider.

(Sheila Gadell): Can you repeat that please?

Ebony Brandon: Any adjustments will be reflected on the final PS&R. If the cost report has already had a final settlement, the amount will be demanded and then offset against future claims if it's not paid in full by the provider.

(Sheila Gadell): Thank you.

Ebony Brandon: You're welcome.

Operator: Thank you. The next question is from (Alene Roberts) from Kentucky. Your line is now open.

(Alene Roberts): Hi. Thank you for having this beneficial conference call. I had one question - well actually two. Will the delay caused by the GAO decision, waiting on that, delay the start of the RAC for instance in Kentucky we're slated now to start August 2009. Do you anticipate that that would be pushed back?

Ebony Brandon: No.

(Alene Roberts): So February even if you have to wait until February, everything's going to churn forward according...

Ebony Brandon: Yes.

(Alene Roberts): ...to your expansion schedule.

Ebony Brandon: Yes.

(Alene Roberts): Okay. Okay. One other question. Well two other questions. The medical record limits going to change you think due to AHA working with CMS on it and if so, when?

Terry Lu: We have spoken with the AHA as well as the AMA on the medical record request limit.

(Alene Roberts): Okay.

Terry Lu: CMS reserves the right to review the limit and adjust them at a future date. We at this point do not have plans to do so nor do we have a fixed timeline. It would just sort of depend on...

((Crosstalk))

(Alene Roberts): Do you have a ballpark idea?

Terry Lu: We could conceivably adjust the limits annually. But beyond that we haven't really set a schedule for adjusting them or a process or anything like that.

(Alene Roberts): Okay. I just want to be able to communicate to our medical staff as well as our hospital. The last question I appreciate that these RNs that are doing the reviews are using LCDs and NCDs but I have read that the RACs have so called proprietary criteria

similar to what we in hospitals use in InterQual and Milliman and Robertson.

And they're not under any requirement to share that at all. That was the experience in the demonstration projects. So I guess I'm just concerned how can you guarantee (inter rated) reliability when there's not a consistent inpatient or for, you know, what radiology and InterQual has like radiology, physical therapy, all of rehab therapies and all. Just to have consistent guidelines to have that (inter rated) reliability.

Melanie Combs Dyer: This is Melanie. And you are correct that we have not required the Recovery Audit Contractors to purchase any particular brand of screening tool, of screening criteria, like InterQual or Milliman or - they can buy one of those. They can buy both of those. They can use their own as they can use different criteria for different types of claims. It's totally up to the Recovery Audit Contractor.

What's important to keep in mind though about that screening criteria is that it's just that. It's screening criteria. If you pass it, it does not necessarily mean that the claim in covered, correctly coded and medically necessary. If a claim fails it, it does not necessarily mean that it should be denied.

It is totally up to the Recovery Audit Contractor nurse reviewers to use their clinical judgment in determining whether or not a service was medically necessary in the inpatient setting.

(Alene Roberts): Right.

Melanie Combs Dyer: That being said, we do require each one of our Recovery Audit Contractors to operate an internal quality assurance program that would most likely involve some kind of (inter rater) reliability where they would have different nurses review the same kind of claim and make sure that they're coming out with the same determination. And if they're not, put in place corrective actions to make sure that their nurses are reviewing the same way.

(Alene Roberts): Okay. I'm - this is the first I've heard that the medical director really has no role in the denial. And that concerns me especially since there is no consistent criteria being applied.

So, you know, I mean that's the value of like first level review when the nurses look and use the criteria. Then the second level in, you know, for any other - any other commercial insurance or Medicare reviews in hospitals, then you go to your physician advisor. And I'm just real concerned about that. But we'll be watching and preparing. Thank you.

Operator: Thank you. The next question is from (Sue Baker) from Iowa. Your line is now open.

(Sue Baker): ...access and we do method two billing for our ER position. How will that be affected by the RAC? Will that be under the hospital portion or will it be under Part B for 1500s? We don't bill 1500s that are (unintelligible).

Melanie Combs Dyer: This is Melanie. And it will be however it is that you submit claims today; you will continue to submit claims. And the Recovery Audit Contractors will be given all the claims for their

jurisdiction and they will pull the ones that they believe contain improper payments and look at them more closely and ask for medical records where complex review is needed in select improper payments where they find them. So it's really no different than how things are working today.

(Sue Baker): Thank you very much.

((Crosstalk))

Operator: Thank you. The next...

Ebony Brandon: (Amanda) we have time for one final question.

Operator: Okay. The next question is from (Dana Kaufman) from Texas. Your line is now open.

(Dana Kaufman): Yes. My name is (Dana Kaufman) from Texas Healthcare Computer Corporation. We're a billing agency. And my question is, I may not have clearly understood, related to how the RAC compares to what the CERT process currently is. That's the first question.

Melanie Combs Dyer: This is Melanie. And there are a number of differences between the CERT process and the Recovery Audit Contractor process. CERT is pulling a random sample of reviews. They look for an estimate. Their goal in life is to come up with an estimate based on their statistically valid random sample of claims.

On the other hand, a Recovery Audit Contractor is not just pulling claims randomly. Instead they are targeting their reviews to the areas where they believe it is most likely that they will find improper payment. So that's the biggest difference.

Another difference is that the CERT contractor has a limited number of medical records that they are looking for each month from providers in a given state and the Recovery Audit Contractors really don't have a limit in terms of the number of claims that they can look at. Although as you've heard Terry Lew talk about, there are medical record limits. So there are limits on the amount of complex reviews that they can do on any given provider.

Other than that, most everything else is pretty similar between the way a CERT contractor and a Recovery Audit Contractor would operate. They both would issue a medical record request letter. They both would have a certain timeframe for reviewing the record and a certain amount of time to issue a letter back to the provider with the review results.

(Dana Kaufman): Okay. So it is possible to potentially receive a CERT audit and a RAC audit, possibly

Melanie Combs Dyer: Like Ebony said earlier, we have a system in place to make sure that no single claim gets reviewed by two different entities.

(Dana Kaufman): Okay. I misunderstood that. I'm sorry.

Melanie Combs Dyer: That's okay. If the carrier, the FI, the MAC, the PSC, the (Zpic), the QIO, if anybody reviews a claim, it's off limits to the RAC.

(Dana Kaufman): Okay. So when you do reviews regarding RAC, are you going back to Medicare's (unintelligible) (timely filing frame), which I heard earlier was you weren't going past 10-1-07. The reason I ask that is because currently we have some customers that have (unintelligible) and diabetic claims with dual (modicums KS and KX) instead of one or the other.

Medicare came back issued either a - told them that they were going to recoup the money or they could appeal it. They pay and sent the money back quickly. When they refilled the claims, they were told they were outside timely filing and they should have never sent the money back. They should appeal the claim. Is that possible with RAC for that scenario to happen as well?

Melanie Combs Dyer: Is it possible for a contractor to make a voluntary refund and then later wish that they could submit a claim? I guess that's possible but that's irrelevant to the RAC program.

(Dana Kaufman): Well our concern is that, you know, they're getting a demand letter. They don't want to get in trouble for not sending the money back in a proper time because they didn't feel like they were ready quick enough for an appeal. But if you're able to go back and recoup money for so far - so far back, why can't they in turn be able to re-file the claim and not be denied for timely filing.

Melanie Combs Dyer: Whatever the normal rules are for claims filing timeliness, the same rules are in place during the Recovery Audit Contractor program. And just to refresh your memory, the look back period will eventually be three years for the permanent RAC program.

Although at the very beginning, we have limited that so that the look back period cannot go any further back than 10-1-07. So if the RAC program actually gets up and running in lets say February of '09, initially that look back period would be about 14 or 15 months.

And then a month after that it would be an extra month and then a month after that it would be another month. And it would just keep rolling forward until it got to be a three-year look back period. And it will always remain a three year look back period from that point forward.

(Dana Kaufman): That's my concern because if you're going back potentially later on three years, if I guess some of the (till) process then that's when you would determine if you could - if they - supplier one, they could get paid. But if they filed - if they return the money and then wanted to re-file the claim with correct information, they're outside of the timely filing.

Melanie Combs Dyer: In those cases it's the best thing for the provider to do would be to appeal the determination.

(Dana Kaufman): Do not send the money back. Okay. That's helps with my answer. Thank you.

Natalie Highsmith: Okay (Amanda), we have exceeded our 3:30 hour here on the east coast. I will now turn the call over to Ebony Brandon for closing remarks.

Ebony Brandon: We want to thank you all for listening today. Please check our Website at www.cms.hhs.gov/rac for updates on the program. If you have any additional questions or want clarification from something for today's call, please email them to rac@cms.hhs.gov. Thank you.

Natalie Highsmith: (Amanda) can you tell us how many people joined us on the phone?

Operator: Eight hundred and sixty.

Natalie Highsmith: Eight sixty. Wonderful. Thank you.

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

END