

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Fee-For-Service Recovery Auditor Prepayment Review Demonstration
Wednesday, December 21, 2011
2:00PM – 3:30PM ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss the recently approved Recovery Auditor Prepayment Review Demonstration that will begin January 1, 2012.

This Special ODF is designed specifically for Medicare Fee-For-Service providers who may be subject to Recovery Auditor review in the 11 approved demonstration states: CA, FL, IL, LA, MI, MO, NC, NY, OH, PA, and TX. Recovery Auditors will review claims before they are paid to ensure that the provider complied with all Medicare payment rules. These reviews will focus on certain types of claims that historically result in high rates of improper payments. Initially, Recovery Auditors will review short stay inpatient hospital claims. This demonstration will also help lower the error rate by preventing improper payments, rather than the traditional “pay and chase” methods of looking for improper payments after they have been made.

During this ODF, CMS will provide an overview of the Recovery Auditor Prepayment Review Demonstration, including:

- Why the Demonstration is being implemented;
- How it will impact providers in the affected states;
- Specific operational details regarding the reviews; and
- Where to find additional information.

After CMS' presentation, participants will have an opportunity to ask questions.

Discussion materials for this Special ODF will be available to download at <http://go.cms.gov/cert-demos> on December 19, 2011.

We look forward to your participation and comments.

Special Open Door Forum Participation Instructions:

Dial: 1-866-778-8325

Reference Conference ID#: 36846735

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

An audio recording and transcript of this Special Open Door Forum will be posted to the Special Open Door Forum website: http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around December 29, 2011 and will be 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.gov/opendoorforums>.

Thank you for your interest in CMS Open Door Forums.

Audio file for this transcript:

<http://downloads.cms.gov/media/audio/PaymentStandardizationandRiskAdjustment122111.mp3>

Centers for Medicare & Medicaid Services
Moderator: Natalie Highsmith
December 22, 2011
2:00 p.m. ET

Operator: Good afternoon. My name is (Sarah) and I'll be the conference facilitator today. At this time, I'd like to welcome everyone to the Centers for Medicare and Medicaid Services Medicare Fee for Service Recovery Auditor Pre-Payment Review Demonstration Special Open Door Forum.

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

Ms. Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, (Sarah), and welcome, everyone to today's Special Open Door Forum. This Special Open Door is designed specifically for the Medicare fee-for-service providers who may be subject to recovery auditor review in the 11 approved demonstration states.

During this Open Door today, CMS will provide an overview of the Recovery Auditor Pre-payment Review Demonstration including why the demonstration is being implemented, how it will impact providers in the affected states, specific operational details regarding the reviews and where you can find additional information.

Materials can be found on these following Web sites: go – which is GO – .cms.gov/cert – C-E-R-T – -demos – D-E-M-O-S.

OK. I will now go ahead and turn the call over to Mr. George Mills who is the Director of the Provider Compliance Group here at CMS.

George Mills: Hello everybody out there on the phone line. Again, my name is George Mills, Jr. I'm the Director of the Provider Compliance Group in the Office of Financial Management here in the Centers for Medicare and Medicaid Services.

Today, the purpose of our call is to discuss a demonstration project which will allow our recovery audit contractors to conduct pre-payment review on a limited basis and we're going to go into an operational discussion of how that's going to work as well as the discussions of the DRGs that we're going to start with as well as on the line is – from our CERT contractor is Dr. Cope who at the end will describe what the problems are with those DRGs that we're seeing through the CERT program.

But before I get into that, I'd like to talk about what we do here in PCG. And we – in this group, we have some major business functions – one, we run the Medicare fee-for-service medical review program, we rerun the recovery audit program, we measure the rates of error for both the Medicare program fee-for-service as well as the Medicaid program.

And then we also have people working our projects such as electronic medical record submission, the esMD project for people that might be aware of that as well as people that conduct data analysis and work on corrective action plan.

So one of the things I want to focus on is why we're doing this demo and give an overview of what that process is. Every year as part of the agency's financial report, CMS is required to produce an estimate of the improper payments in the Medicare program. The estimate of improper payment is not an estimate of the rate of fraud. It's an estimate of the rate of error in the Medicare program.

Although all fraud is improper, not all improper payments are fraud. And one of the problems that we face is when we announced the error rate every year that people confuse that that is a rate of fraud, but no, it's a rate of error.

Some of the error may well be fraud but there is nothing called the fraud rate now so I just want to make sure that that is clear.

We issued our financial report and this year, the rate of error in the Medicare program was 8.6 percent which translates into nearly \$29 billion in error. Just to give an overview of the Medicare program, Medicare in fiscal 2011 paid over 1.2 billion claims representing payments of in excess of \$336 billion.

If Medicare was a country – Medicare fee-for-service was a country, we'd be the 30th largest economy in the world. So it just gives you a sense of how big the program is and the issues we're facing here dealing with improper payment.

When we look in the CERT report, one of the areas that we find issues with is on short hospital stays. So we looked at the rate of error and part of our corrective actions for the CERT report is to identify areas that are vulnerable and to develop a corrective action for them. Part of our corrective action is to implement this pre-payment review on short hospital stays.

What Dr. Cope will talk about are what the problems are that we're seeing with the short hospital stays. I'll sort of steal a little bit of its thunder that there's three major errors of category of errors on short hospital stays.

The first is that we see that the claim is incorrectly coded so we have the wrong DRG on there. The second issue is we see people coming into the emergency room that should have been in observation rather than be admitted. And the third major issue is that people are getting elective surgery on a short day stay when they should have been done in an out-patient.

So you're going to hear a discussion of that by Dr. Cope in greater detail related to this. So we will move into that, but that's the reason we're starting this project. This is just the – we're announcing today the first DRGs that we are going to look at.

As the project moves forward, there will be additional DRGs added to the list that will be announced at a later date. We're releasing these now that these are the areas that are going to be in focus and the depending on how well the

program is working, we will move into other areas and release those DRGs at that time.

These DRGs come from our analytics from our CERT report that showed that there are problems with these types of claims and these are why we're focusing on these specific DRGs and the later DRG.

So that's an overview of why we're doing this project as well as to identify potential fraud that may be out there related to these types of claims and work with our counterparts in the Center for Program Integrity. If potential fraud is identified, we will be working with them to make referrals to law enforcement.

So with that being said, I'd like to turn it over and we're going to talk about how the process will work and I'm going to turn it over to Amy who will introduce herself.

Amy Cinquegrani: Thanks, George. Hi, everyone.

My name is Amy Cinquegrani. I'm with the Division of Recovery Audit Operations which is part of the Provider Compliance Group at CMS.

I'm going to be going through some slides that we released on our Web site. If you don't have that or the slides in front of you, you can get them at the Web site that Natalie mentioned which is go.cms.gov/cert-demos. You can click on the link on the left or the Recovery Audit Demonstration and the slide presentation is one of the links at the bottom of the page. So hopefully everyone has that information, but if not, I just wanted to let you know how to find it.

So I'm on slide 2 right now, and George pretty thoroughly described the purpose of this demonstration, but just to reiterate, you know, our main goals of the demonstration are really to prevent improper payments before they are made and to lower the error rate.

And as George described, this demonstration is initially going to focus on claims with high rates of improper payments which are those short in-patient

hospital stays, and again, we'll hear from Dr. Cope about what those are later in the presentation.

Slide 3 has then basic details about the demonstration. Some of you may be familiar with from the press release and some of the information on our Web site but this demonstration will start in the New Year, January 1, 2012, and will run until December 31st, 2014.

This demonstration is limited to 11 states. Seven of the states are (inaudible) states which are California, Florida, Illinois, Louisiana, Michigan, New York and Texas. And an additional four states that have high volumes of short in-patient hospital stays. Again, those are Missouri, North Carolina, Ohio and Pennsylvania.

And just to clarify because we had some questions in advance on this issue, the facilities affected will be those that are physically located in the above states and bill to the F.I. or MAC that is actually assigned to that state.

And something else we wanted to clarify is that this demonstration will not replace the MAC or F.I. pre-payment review that is going on now. They're going to continue reviewing claims on a pre-payment basis as well. This demonstration is just again another tool to help lower the error rate.

However, we're going to have some pretty significant collaboration with our contractors to make sure that they wouldn't be reviewing the same thing. The providers will not be subject to reviews for the same topics by two different contractors.

Moving on to slide 4, we have some operational details about how the demonstration is actually going to work. The additional documentation request will actually come from the F.I. or the MAC.

So when you submit your claim, you will see that that claim, you know, will be suspended for additional review and then you'll get that additional documentation request which will specifically list who to send the medical records to.

So please make sure you review the request carefully because it will tell you, you know, either send your request to the MAC or send your request to the recovery auditor that will be performing the review and will have the applicable address on the letter.

As with the current MAC pre-pay review process, providers will have 30 days to send in documentation. Again, we're trying to mirror the two processes as much as we can so providers aren't having to learn new rules or things. So you'll have 30 days to send in the documentation and the claim will auto-deny if your documentation isn't received within 45 days. So please remember of those days.

The recovery auditors will review your claims and they will communicate back to payment determination back to the F.I. or the MAC. You as a provider will receive that payment determination whether it's payable or denied on your remittance advice. That's the communication that you'll receive from the claims processing contractor as to whether or not the claim will be paid.

The recovery auditors will continue to send a detailed review results letter that they send now for those complex reviews that has, you know, information, you know, patient-specific and claim-specific information about what they reviewed and the reason for the denial.

Moving on to slide 5, we have some more operational details. We've had – we have had some questions about the limits on pre-payment reviews and we did want to let providers know that the limits for pre-payment reviews wouldn't exceed the current post-payment's additional documentation limit that we have now.

So for example, if your limit for post-payment review is 50, the maximum that you could receive for pre-payment reviews will be 50 as well. But we want to reiterate that again, this is just a maximum. There is no set minimum for this program and we fully expect that the number of pre-payment reviews will be significantly less than what the maximum is. No one is reviewing, you know,

100 percent of these claims that are coming in, you know, for the specified DRGs. It is going to be a percent itself. We didn't want to go over that.

Claims that are denied on pre-payment review, they have appeal rights and those are the same appeal rights as other denials that you may be familiar with. And the appeal timeframe actually starts with the date that you're notified of the denial on your remittance advice.

Moving on the next bullet, this only applies to claims that are denied for non-receipt of a medical record, so again, if that timeframe – 45-day timeframe has expired and you haven't submitted the medical record back in and you subsequently appeal that claim and then send in a medical record to your F.I. or your MAC, those claims and that documentation will actually be sent back to the recovery auditor so they can complete the review and that will not count as an appeal.

This is something that currently, you know, you may be familiar with or F.I. or MAC pre-payment review but really isn't done on the post-payment side but – so we did want to let you know that. Again, this is only for appealed claims that were denied for non-receipt of a medical record.

And lastly, we do just want to remind you that these claims will be off limit from future post-payment review from the MAC and the recovery auditor. We'll be still utilizing the data warehouse that some of you maybe are familiar with now which is sort of the clearinghouse for all of our claim activities so we know that there is, you know, not duplication of efforts for the same claims.

Moving on to slide 6, we have some information that I'm sure a lot of people have been waiting for. We are listing the DRGs that the recovery auditors are going to focus on for the first phase of the demonstration.

We can see that starting in January, certain claims that are billed with MS-DRG 312, syncope and collapse, will be held for pre-payment review by the recovery auditors. So that's sort of the first one that you can see and we have some others listed there for about the first six to seven months of the demonstration.

Slide 7 has some important contact information that you may want to keep in mind. For any questions about – you know, specifically about the demonstration, you can contact our recovery auditor email box here at CMS which is rac@cms.hhs.gov .

And again, for the slide presentation and for any other information that we'll be updating on our Web site, please visit go.cms.gov hyphen – or slash, sorry, cert-demos. I'll say that again, go.cms.gov/cert-demos . And there is a link on the left side of the Web site that lists the Recovery Audit Demonstration. Click on that and we will be updating the Web site with some FAQs and some other information as we go along.

And that actually takes care of the basics of the demonstration, and we definitely have plenty of time for Q&A at the end, but we are going to turn it over now to Dr. James Cope who is one of the medical directors for our Comprehensive Error Rate Testing contractors.

And as George Mills mentioned earlier, he's going to describe some of the errors that they're seeing over in the CERT's world for the DRGs as to sort of give a little bit more background about why we're going to continue reviewing these things in great detail.

Dr. Cope?

James Cope: Thank you. Thank you very much. And good afternoon to everyone.

I'm going to talk about some of the issues we have seen at CERT when reviewing these groups of DRGs that you just saw on the slide. As George mentioned, there are really three issues in our findings, two of which I'm really not going to address today.

One is coding and coding is certainly not my area of expertise. We do at CERT have a very experienced group of coders and we do this work with occasional consultation with Dr. Perez and our medical directors, however, that's not – I don't think the important topic for today.

I'm also not going to address the issue of short stays for procedures simply because that is not an issue that is involved with any of the eight DRG groups that we showed a moment ago.

Excuse me.

However, I will note that we do at CERT see many cases of short in-patient stays of a day or two where the beneficiary was admitted electively to a hospital for an elective procedure certainly not going to sign the in-patient (inaudible), but then these patients have the procedure on the day of admission. They have a routing recovery (inaudible) complications. They are monitored overnight and discharged the next day. So I guess I did discuss it a little, but that's the nutshell version of the procedure issue.

Now, with some detail about our findings about these various – on the DRGs. As George mentioned, the real issue with these DRGs is that these are cases that were admitted to the hospital generally to the emergency room and after review were felt that they should have a – necessarily could have been taken care of on an out-patient basis that is out-patient observation in general.

As you see, the first of these DRGs is MS-DRG 312, syncope and collapse. I'll give a very common example of this DRG sort of case that we see many times. And I apologize for my voice. I'm just getting a little (inaudible) to the country these days.

A 70-year-old woman was sitting in church and (inaudible) over in the pew. She was unresponsive for a minute or two according to the EMS report. And on arrival in the emergency room, she was awake and alert and oriented times three. Her vital signs were stable.

Her physical exam revealed a normal exam including no focal neurological deficits. The lab work was unremarkable. CT of the head was normal. Her cardiogram was normal and telemetry monitoring showed a normal sinus rhythm.

This beneficiary was admitted to a telemetry unit, monitored overnight and discharged in the morning to follow up with her primary care physician. So

again, the decision of the reviewers including one of the medical directors (inaudible) this beneficiary certainly could have been handle as an out-patient observation case.

The second category on the list is MS-DRG 069, transient ischemia or a transient ischemic attack. An example from our reviews is this, a 69-year-old gentleman was noticed by his wife to have slurred speech and left facial drooping.

Two hours later in the emergency department, he was awake and alert and oriented times three. His vital signs were stable. His speech was clear and no facial droop was appreciated.

His physical exam was otherwise unremarkable including any lack of any focal neurological deficits. Head CT, negative. Lab work, normal. Cardiogram, normal. Telemetry, normal sinus rhythm.

The gentleman was admitted to a telemetry bed and monitored overnight. While on the hospital, he was seen by a neurologist and his carotid ultrasound showed minor stenosis bilaterally. He was discharged home to follow up when this physician drops. Again, it's similar decision as before.

The next category, and I'm lumping a little here, MS-DRG 377, 378 and 379 are gastrointestinal hemorrhages. An example that we see very often is (inaudible).

A 72-year-old man went to the emergency department because of rectal bleeding. He noticed red blood in the toilet after his morning bowel movement. In the emergency department, he was in no distress, his vital signs were stable.

Physical exam was unremarkable except for hemoccult positive stool. His lab work was normal with a hemoglobin of 13.2. He had no coagulopathy on further laboratory testing.

The repeat hemoglobin four hours after arrival was 13.1. He was admitted and monitored overnight. While in the hospital, he was seen by a

gastroenterologist and had a normal colonoscopy. His hemoglobin continued to remain stable and he was discharged to follow up as an out-patient.

My final two examples are all related to DRG 637 through 639. These are the diabetes DRGs. And I'm giving two examples because as many of you I'm sure are aware, most of the cases of this nature that ends up in the hospital emergency department fall into one or two – of two categories, that is too much or too little blood sugar.

The first is, a 77-year-old diabetic woman noted at home by her family to be lethargic. EMS arrived and discovered a fingerstick glucose to be approximately 50. EMS administered (v50) intravenous dextrose.

In the emergency department sometime later, she was awake and alert and oriented times three. A serum glucose was 140. Other laboratory data was normal. Her physical exam was normal without any abnormal neurological findings.

She was admitted, monitored overnight. Her blood sugars remained stable and she was discharged home in the morning.

The second example, a 73-year-old man with type 2 diabetes for many years was noted by the staff of an assisted living facility to be more confused than normal. They did a fingerstick glucose and it was 420.

In the emergency room, the beneficiary was awake and alert, somewhat confused. Exam otherwise was unremarkable. Abnormal labs including – included a serum glucose of 370 and a mild elevation of his BUN and creatinine when compared to his baseline.

He had a head CT which was negative. He was admitted, treated with I.V. fluids and monitored overnight. The next morning, his lab work returned to baseline and had his mental status. He was discharged to follow up in the near future with his regular physician.

Again, as noted earlier, both of these cases were felt by the reviewers and one of the medical directors to be cases that could have and therefore should have been dealt with as out-patient observation services.

With that, I'll end and hand it back to Amy. Thank you.

George Mills: Yes, this is George. Thank you, Dr. Cope.

These are just examples of what we see. I think they're pretty typical of the kinds of errors in the future – our future DRGs which we'll announce at a later date, we'll get into some of the procedures.

I just want to alert people about what the MACs do and what the RACs do every day because there was some confusion a few weeks ago that – about what this demo was and what it was doing.

Under the Program Integrity Manual and ours is Operating Instructions to Medicare Administrative Contractors, they use CERT data on a local basis, develop a medical review strategy to address the error rate that they see in their local area.

These DRGs here appear to be problematic across the whole country. The MACs developed a strategy based on the data they get from CERT that looked at their problems in their area. So if you would go onto a MAC's Web site, you might see a MAC doing a review on various DRGs or other kinds of services. So that is part of their regular daily medical review activity. That's what they do.

These are totally different projects and you shouldn't glean that if there is 15 widespread DRGs being done at a contractor in a certain part of the country, that that means that there's problem everywhere in the country.

I would refer people to the CERT report which was – for 2010, not the 2011. But if you look in there, we have by state what error rates are and they differ dramatically from state to state. So you cannot conclude that because one MAC is reviewing a group of DRGs or a specific service that that is a problem everywhere in the country – that is not true.

So you need to be very careful when you're making extrapolations as to, "Oh, this MAC is doing it so that means it's got implications for the whole country." That is not true. Look at each MAC. They publicized their issues where they're doing widespread reviews for recovery auditors where it's outside the demo but in the course of their normal work, the post-payment review that they do.

Every MAC is a condition of the requirement of being in the program has to post the issues that they're reviewing. If you go to the RAC's Web site, there is every issue that the RACs are reviewing. It's very public. People know in advance that these are the items that the RACs are looking at. So you go to the RAC Web sites.

There are over 2,000 issues out on the Internet that the RACs are looking at in a post-pay basis. That is different that this demo. This demo is right now only these DRGs on a staggered basis to make sure that the process is working right and that the coordination between the MAC and the RAC.

I just want to re-enforce that one other thing is that Amy said in her thing, there wouldn't be duplication to the extent that we pick a DRG that will be off boundary for the MAC to review. So the extent that it's in the demo, the MAC will not be reviewing it.

And I wanted to point out that this is not a 100 percent review of every claim for that DRG. This is a limited staggered approach to implementing this demonstration. And we continue to get comments from people and to the extent that there are reasonable accommodations or changes we can make into the processes. We're more than willing to listen to that.

And if people have comments on the process, there are email addresses at the end of there and we're more than willing to hear good suggestions. We don't have a monopoly on good ideas here. If there's a better way to do it, we will consider that.

So with that, I would like to open this up to Qs and As and I'll turn it over to our moderator.

Natalie Highsmith: OK, (Sarah), if you can just remind folks on how they can get into the queue to ask their questions? And everyone, please remember when it is your turn, to restate your name or state you're calling from and what provider or organization you're representing today.

Operator: At this time, I'd like to remind everyone, in order to ask a question, please press star and then the number 1 on your telephone keypad.

Your first question comes from the Larry Biegelsen of Wells Fargo, your line is now open.

Larry Biegelsen: Good afternoon. Thanks for taking the question.

Can you hear me OK?

Natalie Highsmith: Yes, we can.

Larry Biegelsen: Great.

You said that there wouldn't be 100 percent of claims that are reviewed pre-payment. Do you have any idea what percent of claims among these targeted DRGs will be reviewed pre-payment?

George Mills: Well, we're going to start slow and work up. We don't have an exact number right at the moment but we're going to – again, this is focused on short stay as opposed to all the DRGs here. And so we're going to start slow and move up but we – I don't have an exact figure to make public at this time.

Part of it is going to depend on the problem. If in a certain state we see more problems then we'll raise the level of review.

Larry Biegelsen: I mean any ballpark, are they going to be less than 10 percent, greater than 50 percent, any color?

George Mills: It's hard to say because this is just an estimate going forward. I think in our (PRA) package, we've said, once fully implemented, the RACs will be reviewing about 100,000 claims across the whole country when this

demonstration is completely implemented, but we're a long way from being completely implemented.

Larry Biegelsen: And at this point, what percent of claim do you think RACs currently audit post-payment?

George Mills: It's relatively small. I would refer people to our (PRA) package that we had released talking about the level of pre-payment medical review which include the RAC demo in that package.

We estimate that nationally including this demo that on a pre-payment basis that we will review next fiscal year – calendar year approximately 2.7 million claims. That's 2.7 million claims out of 1.2 billion claims and \$336 billion of payment. If you do the math, that means we have a pre-payment review of 0.0225 percent. So I – you know, I just to have a people remember them in.

Larry Biegelsen: And then can I ask a question about the MAC pre-payment reviews or...

George Mills: Yes, yes, that's fine.

Larry Biegelsen: So we've seen the details on the program at Florida. I mean there – from the Web site in Florida, it looks like there were some interactions with CMS based on my interpretation. Do you see what Florida is doing is something that other states are going to implement in the future...

George Mills: Well, I would refer you to each MAC's Web site where they already have this. If you go there, people are doing things, but that was the point of my statement earlier what that – what might be going on in Florida might not be the same issue that's going on in North Dakota.

When you look at the error rate by state, they are pretty different and the issues are unique and then a lot of it depends on the types of providers that are within the state. So I don't think it's the best idea to extrapolate what's going on in Florida to the rest of the country because I don't necessarily believe that in every state, they have the same issues that might be going on in Florida.

Larry Biegelsen: Lastly for me, why was this medical necessity identified as one of the three areas of concern? Does that mean that it's – it is not an area of concern for CMS or doesn't contribute...

George Mills: But that's really what we're saying is that it is a matter of a necessity issue. When Dr. Cope described that the person should have been an out-patient rather than in-patient, that that's what's we're saying, is that it wasn't medically necessary for them to be an in-patient.

That doesn't mean that they shouldn't have gotten any service or that it was totally unreasonable. Whatever the hospital did, the issue is whether they needed to be an in-patient as opposed to being out-patient.

So I – you know, when we use the word medical necessity, it doesn't always mean that it's inappropriate. And I think I would like to caution people, when you hear us use the word short hospitals, it's almost entirely this issue about whether they should have been in-patient or out-patient, whether it's – they came in through the emergency rooms or whether it was an elective surgery. That's really the big issue here, is the in-patient versus out-patient. So thank you for your questions.

Larry Biegelsen: Thanks.

Natalie Highsmith: OK, thank you.

Operator: Your next question comes from the Wanda Thompson with Carolina Health care. Your line is now open.

(Tom Cone): Hi. This is (Tom Cone). I'm sitting with Ms. Thompson but I have questions if that's OK? And I had three and I think they're all short answers.

The first one is, how does this relate to the part A to B rebilling demo project? And if you participate in that and give up your appeal rights for short stays, does that mean you've given them up for this project as well?

George Mills: Well, to the extent that there is either pre-pay or post-pay done whether it's in the demo or in a post-pay basis or bond done by a RAC or a MAC, if you're in the A/B rebilling demo, you can rebill.

Tom Cone: But can you appeal?

Connie Leonard: No. You may not appeal at your end. I just kind of want to address (inaudible) recovery audit operation (inaudible) and the part A to part B rebilling demonstration. You may rebill for your (inaudible) and services if a pre-pay claim is denied (inaudible) will not have this appeal rate for that particular plan.

Tom Cone: OK. That's what I was afraid of.

The second is just clarification on the ADR limit. This is in addition – it's the same limit but it's in addition to the post-payment review limits?

George Mills: Yes.

Connie Leonard: Correct.

Tom Cone: OK. And then the third is, is there – do you have clarification on when the review letters will be sent relative to the R.A.?

Connie Leonard: But the review results will always go out prior to a provider (inaudible) R.A. Usually, it's just within a couple of weeks and we would expect the same especially given that these are pre-pay and not post-pay and there's the timeframe for the provider – for the MAC to make payments to the providers. So I'm going to think it's probably going to be at most two weeks, seven to 10 days probably.

Tom Cone: OK. Thank you.

Operator: Your next question comes from Karen Robinson of Mercy Medical Center. Your line is now open.

Karen Robinson: Thank you.

I have a quick question regarding the process. As I understand it from your presentation that when they're entering the bill, the claim will be suspended. Will it be suspended immediately?

Connie Leonard: The process will be the same as the process the MACs (inaudible) pre-pay review. So the claim will get submitted, it will get suspended from pre-payment review and you'll immediately get notification back that the claim has been suspended and you need to submit documentation.

Karen Robinson: OK. Then at what point will the ADR be sent, at about the same time?

Connie Leonard: Exactly. That notification that you need to get – that you need suspended, that one documentation is the ADR. There will not be another ADR request then.

Karen Robinson: OK. So once it's suspended, that's going to generate the ADR?

Connie Leonard: Correct, yes.

Karen Robinson: So once we receive the ADR then we only have 30 days versus the 45 in the RAC?

Connie Leonard: Correct, because these are pre-pay review.

George Mills: Yes. But we've got comments on that and we're looking at whether we should change out instructions to all contractors about how long we should get people to respond. So we're looking now at that globally because that's the comment we received on – not this demo – I mean this demo and the other demo. So we're thinking about how long that is.

Karen Robinson: OK.

George Mills: So if people have comments on that, we're more than willing to take them.

Karen Robinson: OK. Then the ADR is coming from the MAC?

Connie Leonard: Correct. The ADR will come from the MAC and it will inform you of the address to send (inaudible). It may be back to MAC and then maybe to the

RAC. So you just need to pay attention to what address it says in the letter to send the medical record and documentation to.

Karen Robinson: OK. The concern is similar to the concern with the part A and part B demo. We recently changed our MAC in Ohio and as of this time, we're still trying to determine who is getting those letters from the MAC, you know, across the board. So is there been any discussion on how they can determine where those letters are going to go to?

Connie Leonard: You mean (inaudible) contacted hospitals?

Karen Robinson: Right.

Connie Leonard): That is something that we are looking into from across the board respective of this but we certainly realized that providers like how it used to be or it is currently but we'll change come January 1st on the post-pay RAC site but that would require some (inaudible) changes for CMS. It's something we are looking into but it's not something we can implement right now.

Karen Robinson: OK. And then the last question is, on the R.A., if there has been determined that it was not appropriate for a payment. Is there going to be a code such the N432 or will the N432 be the code?

Connie Leonard: There will be a time as to why the claim was denied as well as the detailed review results letter. That's a good question about the use of N432 and we will see if we'll be able to be used on this pre-pay analysis and make sure we post the question on the Web site.

Karen Robinson: OK. So the review results letter should come back before we see the response on the R.A., pretty similar to what happens with the RAC now?

Connie Leonard: Ideally, you would receive that in the mail prior to doing the R.A. and I know you do today because the RAC has to send the adjustments but given mail time, I guess I could envision situations where you may get the R.A. prior to getting the actual review results letters.

So what I'd like to say (inaudible), you'll get that review results letters first then wit will soon get into the point (inaudible) on records for a particular hospital. It's certainly possibly you might get the R.A. first.

Karen Robinson: OK. Thank you.

Operator: Your next question comes from Deborah Barros of Bailer Healthcare. Your line is now open.

Deborah Barros: Well, all of our questions have been answered. Thank you.

Operator: Your next question comes from Alan Olsen with University of Texas. Your line is now open.

Alan Olsen: Hello. Does this demonstration include the physician services at all? I just keep hearing about DRGs but not anything on the physician side?

Connie Leonard: At this time, it only includes the in-patient DRG. At some point down the road, CMS has finally expanded but obviously there'll be notifications for another Open Door Forum.

Alan Olsen: OK, great. Thank you.

George Mills: Yes, but that's a good point, is that this demonstration down the road might get into other services other than in-patient. So we just want to make that clear. We're starting with DRGs because there is a relatively small number of claims that are in-patient but they have a big impact on the error rate on in-patient spending. It's nearly 40 percent of all Medicare expenditures but way less than 1 percent of claims. So that's why we're targeting this for the biggest bang for the buck. So I just wanted to reiterate that.

Alan Olsen: Thank you.

Operator: Your next question comes from Susan Emanuel of Catholic Health care. Your line is now open.

Susan Emanuel: Yes, hi. Thank you.

I have two questions and a comment. First of all does the facility have any recourse or who do we contact if 45 days has passed and we have not heard anything on the account that they're reviewing?

Connie Leonard: CMS will have a designated point of contact that you can contact if you have not heard a decision from the recovery auditor. We will make sure that that's up on the Web site.

Susan Emanuel: OK. And when you say up on the Web site, on the RAC Web site or on the CERT site?

Connie Leonard: They're on the CERT demo Web site.

Susan Emanuel: CERT demo Web site, not the RAC Web site.

Connie Leonard: Right.

Susan Emanuel: OK.

Connie Leonard: That's a good clarification, is that we will keep pre-pay separate from a Web site perspective from the normal RAC programs but we will add a link to the RAC program just to make it easier for providers because you may well be – very familiar with the RAC Web site. (Inaudible) pre-pay but all the information will be on the Pre-pay CERT Demo Web site.

Susan Emanuel: OK. And then it's still, I think, from the question that the previous caller has been asking or two callers ago, we don't know yet so you guys aren't sure what address the ADR requests are going to be going to?

Connie Leonard: Well, the ADR is – as to who you're going to spend it to?

Susan Emanuel: Well, no, so we're receiving the ADR. One of the things we learned during the demonstration program in California that was painful for everybody is that we couldn't dictate where those letters were going to and nobody at CMS or the MAC could tell us what address or what source of data they were using to generate mail of those letters.

Connie Leonard: As of today, we believe there are videos that are going to come to you electrically. So the claim is going to come in. It will be suspended and you'll get an automatic designation just like you do with the MAC request director for review.

Susan Emanuel: So we're getting an electronic ADR, not a paper ADR?

Connie Leonard: Right. It's the same process the MAC uses today to come back and request additional documentation. So it's the same system that they use to request information. It's not going to be something that sort of come through the mail. So it's coming back to you for the claim system.

Susan Emanuel: OK. So the ADR with all the information you talked about is going to come through electronically, got it. OK.

And then one other point of clarification, and the rest of my questions were all answered, you're going to post then on the CERT Web site, yes, there is going to be a special code that will be used on the remittance advice to tell us that something was part of the RAC pre-payment review or is it will be N432 or what?

Connie Leonard: Correct. I need to verify to see if N432 can be used on this particular claim.

Susan Emanuel: OK, got it. All right. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Linda Berne with Catholic Health Services. Your line is now open.

Linda Berne: Hi. I have a question about the ADR that we received. Right now from the MAC, it has the reason code on there. Are these going to say RAC? I know the address is buried within and it's going to say to send it to the ECS but is it going to be any other identifier there to – so that we can distinguish between the MAC and the RAC?

Connie Leonard: At this time, we believe it's going to be the same information. The only thing they can modify in that request is just the actual address. It certainly will say,

you know, recovery audit contractor and then the name and obviously the address.

Linda Berne: So the recent is going to be the same 5EAOO?

Connie Leonard: Did you receive (inaudible)?

Linda Berne: The reason code on the MAC reviews is 5EA00. So is the reason code for these RAC reviews going to be the same?

Connie Leonard: We'll look into that more of – I would expect it's going to be the same rational for request (inaudible) notification.

Linda Berne: Now, are the RACs going to keep any kind of spreadsheet on their Web site for us to follow the way they do with the post-pays, the one they send out review results/

Connie Leonard: That's a good question. We're going to have the RACs put the information up from the portal. We'll also take that question back and see if that's something that we've included in the ratification for the – to the RAC statement (inaudible) we have one information up on the portal or not, but that's a great question. Thank you.

Linda Berne: OK. And just as far as the (inaudible) hospitals, do we think that they will be more affected by the pre-pay RACs?

Connie Leonard: I kind of say there are going to be more impacts. I would expect that they'll be impacted just like they would in the first (inaudible).

Linda Berne: Thank you.

Maryann Pike: Hospitals are included in this?

Connie Leonard: Yes. The hospital (inaudible).

Maryann Pike: OK. This is Maryann Pike. I'm sitting with Linda Berne. I just have one question.

So by the end of July, we're looking at eight DRGs that will be simultaneously requesting records. Is that correct?

Connie Leonard: Correct. By the end of July, all eight of these DRGs will be in place from a pre-pay perspective so they're not going to necessarily drop off.

Maryann Pike: OK. And then you said that the medical record may be sent to the RAC or the MAC. Can you tell me what – how that – what's the difference there, what was that trigger point be?

Connie Leonard: The RAC is going to be the one that is going to review all of the records. The only trigger point there is potential (inaudible) MAC and the RAC had set up their communication process.

There might be some MACs who want to get in their record and give the RACs access to those systems to review the record and then maybe some, they just want to communicate the RAC – have the RACs review that record at their location and this process and forward the decision. So we are leaving that up to the RACs and MACs to decide how they want to best communicate as long as the RAC is the one making and reviewing the medical record investigation.

Maryann Pike: OK, I'm sorry, I have just one more question. Are they going to be paying for these medical records for copying the medical records?

Connie Leonard: That is still an open question but I think right now, the answer will be yes so we expect that the RACs will pay for the medical records. We will clarify that on the Web site though.

Maryann Pike: Thank you.

Operator: Your next question comes from Eugene Kawasaki of (C4). Your line is now open.

Eugene Kawasaki:Hi. How are you doing?

The 15 DRGs that were identified in Florida, are these DRGs going to be considered in further basis of the demonstration project or part of the future DRGs, are you going to – planning on announcing at a later date?

George Mills: We're going to make that announcement on a later date. We're going to take into account the DRGs that the CERT data as well as the recovery auditor post-pay reviews are identifying as having significant overpayment. So there might be but we will make that announcement later in the year as the demo progresses.

Eugene Kawasaki: And that's – and those – if any of those are (inaudible) future list, is that going to start after July 1st?

George Mills: Yes.

Eugene Kawasaki: And when should we look for a potential announcement?

George Mills: Around May or June at least. We – I mean as you speak, we're staggering this. We want to make sure that it works right. We want to test this concept before we leap into a large number of DRGs so that's why you'll see a staggered approach here to get to full implementation.

So we'll be having numerous outreach and educational calls as well as other things out. I would expect the announcement like in May or June.

Eugene Kawasaki: OK, thank you.

Operator: Your next question comes from Joe Chandler. Your line is – from Freeman Health Systems – your line is now open.

Joe Chandler: Hello. I had a question on, when you do the pre-payment review, will it be not only for making sure they are properly built as an in-patient instead of out-patient but also looking at the DRG to make sure it was correctly coded to the correct DRG?

Connie Leonard: Correct. The recovery auditors will review it both from utilization and a medical necessity perspective. So they'll review the record in totality.

Joe Chandler: OK, thank you.

Operator: Your next question comes from Dr. Ronald Hirsch of Sherman Hospital.
Your line is now open.

Ronald Hirsch: Thank you.

This is for Dr. Cope. You presented a case of a 69-year-old gentleman with a TIA.

James Cope: Yes, sir.

Ronald Hirsch: If we push his data – and you did give us only limited data – into the ABCD squared protocol which is evidence-based, he actually is at over a 4 percent risk of having a stroke in the next two days. That to me is an in-patient. I don't know how you can take TIA and just generalize it to every TIA.

James Cope: Well, and I don't mean to generalize every TIA. I mean these are – these are simply examples of cases we have seen. Certainly, every TIA that we see, we're not going to deny payment.

Every -- clearly, every case is different, every beneficiary is different and therefore, we – you know, we review the entire record that's why many of these – most of these cases of this nature come to one of the two medical directors as opposed to simply going through our screen and mechanism.

Ronald Hirsch: In our experience in the RACs is that they just whole self deny and then they look and say, "Well, the patient never had a stroke therefore never needed to be an in-patient." They're using the retrospectoscope to make these crazy decisions.

James Cope: Well, again, it's nothing for the RAC. I can't really speak to how they review. On the other hand, certainly, we at CERT do not go through this so-called retrospectoscope. We adhere to the (inaudible) the decision that you as the commission have to make and therefore the one we review and based our reviews on is a decision and the information and data that was available at the

decision time that is when one makes a decision whether or not to admit that patient.

Ronald Hirsch: OK. And do you have any evidence-based resource that you would refer to for syncope since that is a great tricky diagnosis for us to sort through?

James Cope: I don't offhand. Again – and I agree, I mean syncope is a very, very – diagnosis and so again, I don't want to imply that we make this blanket decision based on simply on the diagnosis.

Again as you may know, the CERT program uses as its screening tool (intercall) system, however, any in-patient admission that doesn't pass (intercall) criteria goes to Dr. Perez or myself for further review.

Ronald Hirsch: Very good.

And I assume that extrapolation is not going to be allowed.

James Cope: I'm sorry, could you say it again?

Ronald Hirsch: Extrapolation of results, so if I pull 10 of our syncope's and deny eight of them, we can't...

James Cope: I think the answer to that question is no but I'll CMS answer that.

Amy Cinquegrani: And that's correct, extrapolation will not be used in the pre-payment demonstration.

Ronald Hirsch: OK. My one last question, how – once we submit the claim, how long do they have to request records before they can have to pay it without records? In other words, we know we have 30 days to send the documentation but how long can they hold our claim before they can make the decision to auditors?

Amy Cinquegrani: Hi. This is Amy.

The timeframe when I say that RACs have or the recovery auditors have 45 days to review, that is starting from the time that the claim is actually

submitted minus any time that they are waiting for you to send in the records. So it's a little bit tricky but if you send in a record, I'm just going to say...

Ronald Hirsch: So I want to go a step back for that. So we send in a claim for a syncope patient...

Amy Cinquegrani: Right, yes, yes, that's...

Ronald Hirsch: How long do they have to decide whether they're going to audit it or not?

Amy Cinquegrani: Right. That's what we're – I'm going to explain. So if you send in a claim on January 1st and they request the record on January 2nd, that's one day out of the 45 days. Then the 45-day timeframe actually stops after that while they're waiting for you to send in the record. Once the record comes in, that timeframe starts up again for the full review.

So anytime that they are waiting to request that claim actually comes out of their timeframe for them to review it on the backend. So I believe as (Connie) indicated earlier, once the claim is suspended, that ADR will go out, within the next day or so.

Ronald Hirsch: Got it. OK.

Amy Cinquegrani: It's almost an immediate request.

Ronald Hirsch: Thank you.

Operator: Your next question comes from William Martin with American Academy. Your line is now open.

Richard Martin: This is Richard Martin with the American Academy of Orthopaedic Surgeons.

My question is just – is what's presented today was really complicated, what tools do you have now or are you planning for professional organizations to take back to their members and educate their members?

Connie Leonard: Well, I guess we might (inaudible) presentation about – are you talking about what kind of the tools are available so that your membership can make

(inaudible) they're billing correctly in the future – those types of tools or types of tools about this demonstration?

Richard Martin: Actually both.

Connie Leonard: Well, I think about the demonstration, you know, we feel like our slide presentation is probably pretty complete from the perspective of how the process is going to work. It's the same process that, you know, the MACs are using. It's a very similar approach-based process except that, you know, it's happening, you know, prior to payment. You know, everything else from that perspective, you know, stays the same.

The request for the records, the receipt of the record, the review and then the decisions and then based on that decision, is the detailed review results letter (inaudible) can then use to determine if they're going to appeal or not.

And on the flipside as far as, you know, what tool CMS is going to make available so that memberships can – associates can help their membership, you know, bill correctly and not have to worry about, you know, audits in the future.

You know, I certainly would, you know, lead people to the (inaudible) these letters that we've been issuing, you know, every quarter for about a year not and we've gotten really good feedback on it and it includes some examples and, you know, getting some things that are, you know, we are finding, you know, (inaudible) report from the RAC in the recovery audit program, from the CERT program. And then also we'll include in those types of documents things that we're finding on a pre-pay perspective if it turns out that we actually are in fact, you know, finding things.

Then I guess I do just want to point out that certainly different DRGs, you know, as we get into the demonstration and we're not – and maybe some of them in particular space, no, it's a high (inaudible) area or the particular providers, you know, we looked (inaudible) our algorithms and our audits.

They know also that we're just not blindly requesting records to review them, you know, if there's not a history or analysis behind that to reflect a particular

review. So that will occur as we get further into the demonstration and we don't expect providers just be getting (inaudible) request just because it's basically the same with one of these particular DRGs.

Richard Martin: Thank you. I appreciate it.

Operator: Your next question comes from Catherine Hill with American Association. Your line is now open.

Catherine Hill: Hi. This is Catherine Hill with the American Association of Neurological Surgeons.

And a lot of my questions have been answered but I'm really just trying to assess the impact on physicians and in particular on neurosurgeons and our neurosurgeons who do spinal procedures. So the spinal procures, none of those are in the initial DRGs and the letters for this demonstration project go only to hospitals, right?

This is just the – they go to the facility so at this point when we are hearing from our physicians about issues in Florida and MACs that have identified whatever procedure – spinal procedures and others, that is a different process. That is the MAC process. And that is all post-pay or some of the MACs are doing pre-pay?

Connie Leonard: You're correct. This demonstration as of right now, the physician services are not included. It does not mean that down the road at some point of time, you know, we may not announce that – you know, we may announce that we're going to include physician services.

Now, on the MAC side, again, that's just for this pre-payment demonstration on the MAC side. It is certainly possible, you know, that they may choose to do pre-pay (inaudible) physician services and that would still be pre-pay. So this (inaudible) could do pre-pay on – if physician service is claimed after they've reviewed the in-patient claim.

Catherine Hill: OK. So that's helpful. Thank you.

And then in terms – but the RAC for physicians and the – you know, this ongoing RAC, that is a post-pay.

Connie Leonard: Correct. As of right now, any RAC – recovery audit work would be post-pay because they are not included in our initial implementation of demo.

Catherine Hill: Thanks. This is very helpful. And I think that was all my questions. And in terms of before you move on to anything other than what you've talked about today, there would be additional information put out if you move on to physicians or when you move on to additional DRGs, there will be more public education.

Connie Leonard: Absolutely, there will be.

Catherine Hill: Great. Thank you.

Operator: Your next question comes from Andrew Watchfire of Watchfire and Associates. Your line is now open.

Andrew Watchfire: Thank you.

When I looked at the pre-pay review process, one realizes that it takes at least a year to get an (ALJ) decision. So you're going to be providing services on the denial without payment for some time.

And do we have the same system? I know we don't have procedures now but we're expanding to procedures. I think it gives the best kind of example. So let's say you have a cardiac defibrillator. You admit the patient in-patient on their part A and that piece of that medical device cost, let's say, \$15,000.

The first question I guess I have is, if it's denied for wrong setting, do they pay any of the medical device and will they pay at any part of the appeals process or is the physician the same that this is not available for payment?

And so you have a situation where you either have to decide if you go admit in their part A and try to get what you believe is full payment but if you're denied, wait one year, or if you think it should be part A and you have to admit under part B then I guess arguably, it could be a false claim and could

have the impact of raising the deductible for the beneficiaries in the copay. So I'm just trying to see what – when one is making a decision in the procedure-type case, on a denial, will they get paid for the medical device?

Connie Leonard: Well, the appeal process for a pre-pay is the same as post-pay. So you're correct in that, if the claim was denied and then subsequently denied or affirmed that the first and second level is very well could be after a year before that particular case was heard by the administrative law judge.

So, you know, from that perspective, the appeal process is the same. Now, the (inaudible) and if the first and second level, you know, returns the denial, claim payment would happen, that claim would be processed for payment, you know, just like it normally is.

And it certainly is – you know, all providers need to make, you know, accurate decisions when making a mission and they need to review the medical policies and to this situation of a particular beneficiary and determine if there needs to be in-patient or out-patient, you know, certainly from a clinical perspective, you know, if they're going to get payment or how they're going to get payment, you know, should not necessarily factor in. It has to be based on, you know, why is it necessary based on the beneficiary's particular symptoms and what they're presented with at the particular facility.

Andrew Watchfire: OK. And Connie, they wouldn't ever get paid then if it's denied as wrong setting. Even if they billed it initially under part B, they'd get the \$15,000 for the medical device. If it's billed under part A and then denied, they will not get that medical...

Connie Leonard: Yes. They're saying that they would be able to (inaudible) come back in for the ancillary services.

Andrew Watchfire: OK, OK, thank you.

Connie Leonard: Yes.

Operator: Your next question comes from Mary Jedd of HCA. Your line is now open.

Mary Jedd: Thank you.

I have a question, when you were discussing slide 3, you made a statement that hospitals in one of the designated states that were assigned – that were with the assigned MAC for that state would be included in the demonstration.

Does that mean for, example, in Florida where there are some facilities that have not transitioned yet to first coast that those facilities will not be included in this demonstration?

Connie Leonard: Correct. If it basically be located in the state and (inaudible) claims process by the MAC jurisdictions or the F.I. or (inaudible) for that particular state.

Mary Jedd: So the facilities with constant physician services that EPS in Florida will not be included?

Connie Leonard: Correct. (Inaudible) the time of the transition obviously then you very well possibly could be included.

Mary Jedd: OK. I have just a couple other questions. In clarification, when you were talking about the reason codes and the ADR, you stated that you're going to look into a bit more but you thought those would be the same.

And that process can get specific by the contractor as to what reason codes they use for pre-pay and sometimes those will change once the records are received versus while they're waiting for the records. Is that something you're going to look into more so that we can identify what's selected for pre-pay by the RAC versus the MAC?

Connie Leonard: Yes, that is something that we'll look into and we'll have to determine what the availability is for these different reason codes that by the MAC and if they can tailor down for RAC's occurrences.

I'm sure they eventually have some changes on what their ability is upfront to make those changes, you know, right away beginning January, I'm not so sure, but we will definitely look into it more.

- Mary Jedd: OK. And then one final question, is there going to be a discussion period as there is now with the permanent program on post-pay for the pre-pay?
- Connie Leonard: There will not be a discussion period, you know, unless there is an opportunity, you know, right between the time you get the (inaudible) and the review result letters because we think that we give a mail time that that might be, you know, very short in between. There will be no discussion here like there is in the post-pay world.
- Mary Jedd: All right. And I'm sorry, I do have one more final question. The – I know this starts January 1st and given that it's pre-pay, it should be relatively close to date of service but is it date of service driven or claim submission driven? IF we had a claim from November going in January, would that be subject to the review, pre-pay?
- Connie Leonard: Again, that is not a question that I think we have the answers yet so we'll get that up on the Web site (inaudible) claims submission as of January 1st or if it's dates of service. I think we need to look back in our demonstration package and see if we were explicit in that and we'll post that up on the Web site. That's great question. Thank you.
- Mary Jedd: OK. And one more thing, I'm sorry, will the record submission process in esMD be allowed during this demonstration – the electronic submission of the records?
- Connie Leonard: Are you currently submitting it onto the MAC that way?
- Mary Jedd: Yes, we are.
- Female: Yes.
- Connie Leonard: If you currently submit the records to the MAC through the esMD then you'd still be able to use that process pre-pay.
- Mary Jedd: Thank you very much.
- Natalie Highsmith: OK.

Operator: Your next question comes from Page Meeks of New Hanover Regional. Your line is now open.

Page Meeks: Thank you.

Just a further clarification on the request of the records because I understand the time to respond is 30 days. From the time that it appears on the remit because at one point, it was said that there'd be an ADR letter and then another time, it would just be the remittance advice electronic notice.

Connie Leonard: OK. This is how we believe the process will happen. When you submit a claim, that claim will get suspended and the coming back through the system. And I apologize that I don't know what the name of the system is here today. But coming back through the system, you know, it will be your ADR request that will say, "Please submit medical records for this claim. Please send to this location, you know, and within 30 days."

After the review decision happens is when you'll actually get the actual R.A. that will say if the claim was pay or denied. So the R.A. will come after the fact that you should still get an electronic notification through the claim system as you submit the claim into that we know requires an additional documentation before we can make a determination about payment of the claim.

Page Meeks: OK. And, you know, you had said earlier about the time to respond and 30 days would be thought about further. I know that we're starting out slow as was mentioned earlier. Eventually, we'll have multiple and many DRGs and so those requests could be higher in number because R.A. are limited to 500. And so if we have 30 days to respond to this 500 and 45 days to respond to the other 500, a thousand records is quite a burden.

Connie Leonard: Absolutely and we would certainly take that (inaudible) some of those providers if you have large than others and we'll certainly work with our RACs.

And if you do feel, you know, at any particular time, you know, that you are getting, you know, both sides, pre-pay and post-pay by the recovery auditors,

that's really something, you know, that you should discuss with the RAC or certainly discuss with the RAC's point of contact we put there on the Web site because that's really not something, you know, that we want to (inaudible) providers, you know, with was that the right request from both sides.

Page Meeks: Thank you.

And I understand that the request will be as they come in but they'll start from January 1st and then within that 45-day period from January 1st then the number potentially in the future could be 500 during January 1st through the 45-day from that for this project.

Connie Leonard: Right. It certainly will not be 500 anytime in January or anytime probably in the first six months of demonstration.

Page Meeks: Right. But I'm just talking about the timeframe – the timeframe that that limit would be subject to would be from January 1st through the 45 days from January.

Connie Leonard: Correct, through the 45 days, right. And you're correct in that, it's a little but different and in the post-pay RAC (inaudible) basically, medical record requests are completed on a 45-day increment.

So you'll receive one and then you know you're not going to get another one, you know, for another 45 days. And unfortunately, that's not possible in the pre-pay world so you're certainly right and that they will be slowing but that limit will be for each 45-day period.

Page Meeks: OK, thank you.

Operator: Your next question comes from Rita Bunn of Northern Hospital. Your line is now open.

Rita Bunn: This is a point of clarification in the materials that were sent out with regards to this particular conference call. It appears that it specifically applies to the Medicare fee-for-service providers but just to be sure I understand, does it or does it not apply to PPS hospitals?

Connie Leonard: It does apply to PPS hospitals. It applies to anyone who receives payment for Medicare for A or B.

Rita Bunn: OK. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Lorrie Griffin of Trinity Medical Center. Your line is now open.

Lorrie Griffin: Hi. I just wanted to clarify, our facility is located in Illinois, however, we are part of the Iowa Health System and our MAC is through Iowa. I just wanted to clarify that we would not be included in this demonstration project?

Connie Leonard: (Inaudible) information, you will not be included.

Lorrie Griffin: Thank you.

Operator: Your next question comes from Helen Latgow of Metropolitan Chicago.

Helen Latgow: Hi. This is Helen Latgow with Metropolitan Chicago Health care Council. I just has one quick question. The rest of them have been addressed.

When you said in the slides that – can you just clarify this for me – when you say that the medical record provided on appeal will be (inaudible) to the RAC for review, this is only going to happen for a field claims and not for lack of medical record?

Connie Leonard: Correct. If you – if the (inaudible) and the provider does not respond so after 45 days that claim is denied for a lack of receipt of this medical record. And then, you know, (inaudible) days later, the medical records come in, and those will be given to the RACs to review and will not be heard by the appeal department since really their RAC has not had a determination – has not had a chance to make a determination on that claim.

Helen Latgow: OK. That's excellent.

And then just at the beginning – this is really more of a comment but at the beginning of the call, it was stated that CMS is conducting a demonstration to reduce the error rate which is not an estimate of fraud.

So my question is why are the states targeted (heat) states because that's more of a fraud?

Connie Leonard: You're correct. The (heat) initiative is certainly a felony initiative. However, those particular states also have a high error rates and that's why we chose to use those particular seven states as well as four states with the high volume of in-patient states.

Helen Latgow: OK. And on just my last – my last question really is, are there any plans for – does CMS going require the RACs to give priority to pre-payment reviews over post-payment reviews? I mean there are pre-payments so we does in fact have used the reimbursement.

Connie Leonard: Actually, it's just the opposite. CMS do need to modify the RAC contracts to include the pre-payment review. And we also say in language in there that stipulates that they have to ensure, you know, the same volume of post-payment review because we do not want the RACs to just do pre-pay review. Again, we are trying to, you know, do a wide spectrum of reviews because everything has (inaudible).

Helen Latgow: OK, thank you.

Operator: Your next question comes from Frank Urbano from Albert Einstein Medical Center. Your line is now open.

Frank Urbano: Thank you for taking my call. I might have a couple of questions, mostly for Dr. Cope.

I'm the medical director for Care Management on Einstein so I do a lot what Dr. Hirsh did when he was on the call earlier. They're really good questions.

The examples that you gave earlier, are those things that can be shared with us via the Web site? Is it something you're willing to share?

James Cope: That's the question for CMS, but we will certainly look into that.

Frank Urbano: Right. OK, thank you.

The second question is just so I understand, I didn't see them in the slides but just to clarify, the appeals process is the same as any other appeal that we would do for – if we got from our MAC, we've got something from – for example, we use (inaudible) marks so when we get denial from them, it's the same process essentially?

Connie Leonard: It is, yes, it's the same process.

Frank Urbano: Great. Thank you.

And last quick question is back to Dr. Cope, you didn't say it specifically but I think with respect to the criteria, you use (intercall) screening tool and then it goes to the medical director further if there's any discrepancy and (inaudible) (intercall), is that correct?

James Cope: That is correct.

Frank Urbano: Great. Thank you very much

James Cope: You're welcome.

Operator: Your next question comes from (Rachel Stout) of Caremom. Your line is now open. Rachel Stout, your line is open.

Rachel Stout: Hi. I was wondering to get some clarification on the ADRs. Will they distinguish between demo pre-payment reviews and MAC pre-payment reviews so that we can keep track of what's what?

Connie Leonard: That is something that we are going to look into where I'm not sure of the ability of the current system that the MACs use if they could distinguish between normal pre-pay and pre-payment of the demo, but we're going to figure that out and post – submit it up on our Web site so that providers will know.

Rachel Stout: OK. The other question I have is when we currently send our charts to our RAC which is (Connelly), we send them on a C.D. Our MAC is Palmetto and they do not accept records on a C.D. and we are forced to send records on tape or through the U.S. postal service.

Is that going to change so that we can send them on C.D. or send them electronically somehow and that will also give us a tracking method to be able to make sure that they receive those records?

Connie Leonard: If you're sending the records to the RAC then you will still be able to use the C.D. if the RAC and the MAC work something out where the MAC is going to keep getting the ADRs then you would have to abide by the MAC ADR rules.

I think what probably will be best for us to do is (inaudible) the MACs and the RACs determine how they're going to best communicate this thought process (inaudible) by the 11 states and put up in the Web site so the providers know who you're going to send that particular ADR letter to for this demonstration.

I expect especially in January in the beginning of that, most of these MACs are going to have you send it to the particular RAC and in that particular case if you currently send them on a C.D., I know the RAC would love to get the records on a C.D.

Rachel Stout: OK. And then just one more thing I want to verify. The limits on pre-payment reviews wouldn't exceed current post-payment ADR limits. So our RAC limit is 119 charts for 345 days, so that means that we could also get 119 pre-payment requests for 45 days equaling to 238 chart requests for 45 days.

Connie Leonard: That would be your – that would be your maximum number but we certainly don't think it will ever get to that from a pre-payment review perspective.

Rachel Stout: OK. OK, I think that's it. Thank you for your help.

Connie Leonard: Thank you.

Natalie Highsmith: OK, (Sarah), we have time for one final very quick question.

Operator: Your last question comes from Meg Houston of (Inaudible) University. Your line is now open. Meg Houston, your line is open.

Meg Houston: Thank you. My question has been answered.

Operator: Would you like to take another question?

Natalie Highsmith: Sure. That would be – that was not a question so we'll take a question.

Operator: OK. Your next question is from Jennifer Young of TCY. Your line is now open.

Jennifer Young: Thank you. And I'll be very brief.

In the earlier discussion, the next is between the demo and the first coast pre-payment announcement. Someone mentioned that MACs are required to post the issues they are reviewing. Can you tell us where we can find that posting?

Connie Leonard: Sure. Each of the MAC has a particular Web site and if you go to that particular Web site, you know, under their Medical Review Activities, you should be able to find the other things that they're doing (inaudible).

Jennifer Young: Thank you.

Natalie Highsmith: OK. Go ahead and end the call right now since we're about 1 minute shy of 3:30 here on the East Coast. Thank you all again for joining us.

Connie, did you have any closing remarks?

Connie Leonard: No. Only if there are further questions that did not get answered, please feel free to send them in to rac- R-A-C – at cms.hhs.gov. That is an email box into the division and we will certainly try to get answers back to you. And we will post some clarifications on some of the open items in the next few days. Other than that, thank you very much for participating today.

Natalie Highsmith: Thank you. Sarah, can you tell us how many people joined us on the call today?

Operator: OK. We actually had roughly 1,600.

Natalie Highsmith: OK, wonderful. Thank you, everyone. Have a great holiday season.

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

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