Centers for Medicare & Medicaid Services
Special Open Door Forum:
Part A Providers, Recovery Audit Contractor (RAC)
April 8, 2009
2:00 PM – 3:30 PM EST
(Conference Call Only)

CMS is hosting this Special Open Door Forum for Part A provider Recovery Audit Contractors (RACs) on April 8, 2009. 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 92490299

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

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An audio recording and transcript of this Special Open Door 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 Thursday, April 16, 2009 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.

Audio File for this transcript: http://media.cms.hhs.gov/audio/SpecODF_RACPtAProv.mp3

Centers for Medicare and Medicaid Services
Special Open Door Forum:
Recovery Audit Contractor (RAC) for Part A Providers
Moderator: Natalie Highsmith
April 8, 2009
2:00 pm ET

Operator: Good afternoon. And we apologize for the wait and thank you for your patience. My name is (Stephanie) and I will be the conference facilitator today.

At this time I'd like to welcome everyone to the Centers for Medicare and Medicaid Services, Part A Providers Recovery Audit Contractor conference call. All lines are placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question and answer session. If you'd like to ask a question during this time, simply press start and the number 1 on your telephone keypad. If you'd like to withdraw the question, press the pound key.

Thank you. At this time, I'd like to turn the call over to Ms. Natalie Highsmith. Ma'am, you may begin the conference.

Natalie Highsmith: Thank you, (Stephanie), and good day to everyone and thank you for this Part A Providers Recovery Audit Contractor Special Open Door Forum. Today’s Special Open Door Forum is to 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 that will be responsible for identifying overpayment and underpayments in approximately 1/4 of the country.

CMS has planned a gradual expansion to all 50 states. For further details, you can go to www.cms.hhs.gov/rac, R-A-C. I will now turn the call over to Marie Casey, who is the Deputy Director of the Division of Recovery Audit Operations. Marie?

Marie Casey: Thank you, Natalie, and thank you to all who have joined our call this afternoon. We are very pleased to be providing information to discuss our national RAC program.

I do want to point out, to the listeners, that this presentation is primarily geared towards providing information about these RAC implementation and operational processes.

The purpose of this call today is not to answer detailed questions about the RAC program demonstration, the appeals process, or anything related to the recoupment process.

And with that, I would like to turn it over to our Region A Project Officer, Ebony Brandon, who will begin the outreach materials.

Ebony Brandon: Thanks, Marie. Like Marie said, I'm Ebony Brandon. I'm the Project Officer for Region A of the RAC program. I'll present today, with Scott Wakefield, he’s the Project Officer for Region B.

By the end of this call, we hope that you will be able to answer the following six questions. What is a RAC? Will the RAC affect me?

Why RAC? What does a RAC do? What are the provided options? And what can providers do to get ready?

What is a RAC? We think the best way to answer that question is to tell you what the RAC program mission is. RAC is to track and correct past improper payment, so that CMS and carriers, FIs, and MACs can implement actions that will prevent future improper payment.

This will, in turn, allow providers to avoid submitting claims that don't comply with Medicare rules. CMS will be able to lower its error rate and the trust fund will be protected for future Medicare beneficiaries.

Providers want to know will the RAC affect me. Well, the answer to that question is yes, if you bill fee for service programs, your claims are subject to RAC review. The only difference will be when. A map can be viewed on our Web site at www.cms.hhs.gov/rac. There are four regions and, if you're familiar with the DME map regions, our regions align with that.

Some states are yellow, some are green, and some are blue. For the yellow and green states, everything basically started March 1.

The RAC started to receive claims data, provider outreach started, and if provider outreach has already been conducted in your state, then it's possible that you can hear from a RAC pretty soon.

This call today is not considered provider outreach. The RAC will still go out and conduct provider outreach in individual states.

I'm sure that most people know that Medicare has a very high error rate. Of all the agencies that reported to OMB in 2007, Medicare was

number three, with $10.8 billion in improper payment. The data analysis has been done and we've found that Medicare receives 4.5 million claims per work day.

Therefore, we are not really surprised about the high improper payment error rate because, with that volume of claims, they can't possibly receive the type of scrutiny needed to prevent improper payment. So we have the RAC as another tool to try to fix this problem.

I told you about Medicare's error rate. In 2005, Congress required us to conduct a demonstration using recovery auditors. That demonstration operated under Medicare Modernization Act Section 306. The demonstration ran for three years, March 2005 through March 27, 2008.

They required a permanent program be implemented nationwide by January 1, 2010. We now operate under the Tax Relief and Healthcare Act of 2006, Section 302.

Both of those sections gave us the authority to pay the RACs on a contingency fee basis. Meaning they receive a portion of the funds that they recover. Those rates can also be viewed on our Web site. There's a link to our Web site, the Web site that I gave earlier in the presentation, under recent updates and you'll be able to link to - click on that and you can view what those contingency fees are.

The RAC review process, RAC reviews claims on a post-payment basis. They do not conduct prepayment view. They use the exact same Medicare policies as FIs, carriers, and MACs, national coverage in combination, local coverage in combination, and CMS manuals.

They perform two types of review. Automated, meaning they can make a decision without requesting a medical record and complex, they need to contact a provider in order to review the medical records to make a decision about the improper payment.

RAC will not be able to review claims paid prior to October 1, 2007, but they will have a three year look-back period, meaning, as we go forward, we'll eventually get to that three years, but right now, as - they currently have about 12 or 8 month look-back period because they can't go back further than October 1, 2007. By the time we get to 2012, they'll have the full three year look-back period.

RACs are required to employ a staff of nurses and therapists, certified coders, and a full time physician CMD. The collection process is exactly the same that’s utilized by the carriers, FIs, and MACs. You'll see - you'll receive a remittance advice from your carrier, FI, and MAC and you'll see a code on there, N432 and it will say adjustment based on the recovery audit.

That will allow you to be able to track your RAC adjustments versus, you know, other adjustments. The carrier, FI, and MAC will recoup by offset, unless the providers has submitted a check or valid appeal.

There are a few things that are different from the FI, carrier, and MAC. The demand letter will be issued by the RAC. The RAC will offer a discussion period. It’s an opportunity for providers to discuss the improper payment with the RAC.

This is outside of the normal appeal process. You'll still have your appeal right. This is just an opportunity to maybe contact the RAC and

say, you know, I didn't submit certain documentation that will support my claim. And that allows the RAC to review that documentation. If they agree with you, they'll be able to stop that from going any further.

New issues by the RAC will be approved by CMS prior to wide-spread review. That’s something new. We did not have that in the demonstration and all new issues will be posted to a RAC Web site before a wide-spread review is conducted.

The RAC sends in a new issue review proposal to CMS, we will review it. If it’s approved, the RAC must post that to their Web site before they can send the letters to providers.

Providers have a few options, you can pay by check, you can allow recoupment from future payments, you can request or apply for an extended repayment plan, or you can appeal. And the appeals process is exactly the same as the FIs, carriers, and MAC.

To make is easier for you, we have posted a few appeal links that will give you the time frames and talk about Section 935. We've posted that to our Web site. Again, that’s the same Web site that was mentioned early in the call.

Basically, in the demonstration, we have identified three keys to the RAC program’s success, and they are minimize provider burden, ensure accuracy, and to maximize transparency.

Scott will go into more details about these, but I just wanted to talk a little bit about minimizing provider burden. We have done a few things, based on feedback from providers, to minimize burden on providers.

We've limited the RAC look-back period to three years, as I said earlier, and the demonstration was a four year look-back period and we did not have a maximum look-back date. Now, the maximum look-back date is October 1, 2007.

RACs will accept imaged medical records on CD and DVD starting day one. They are required to accept those CDs and DVDs. And we've limited the number of medical records that a RAC can request in a 45 day time period.

So I'm going to turn it over to Scott and he's going talk about what those limits are and talk about some other changes for the program. Scott?

Scott Wakefield: Yes, thanks a lot, Ebony. Hello, everybody. Yes, we'll discuss summary of medical record limits for fiscal year 2009 in a little bit, but please go forward with this in mind.

We are working with the AHA and the AMA on these limits. We're taking a lot of different factors into consideration, so although these are the numbers that we currently have established, there is a possibility that they could change over time, as we go forward with the program.

The inpatient hospital, the skilled nursing facilities, and the hospices will incur 10% of the average monthly Medicare claims per 45 days, the 45 days is a rolling period, per NPI, with a maximum of 200.

Other Part A billers will get one percent of the average monthly Medicare episodes of care per 45 days per NPI, with a maximum of

200. Physicians, including podiatrists and chiropractors will - for sole practitioners, it'll be ten medical records per 45 days per NPI.

Partnerships of two to five individuals will be 20 medical records per 45 days, per NPI. Groups of 6 to 15 individuals will be 30 medical records per 45 days per NPI. And large groups of 15 individuals or more will be 50 medical records per 45 days, per NPI.

Other Part B billers, like DMEs, labs, outpatient hospitals will have 1% of the average monthly Medicare services per NPI per 45 days, again with a maximum of 200.

Get out your pens and a piece of paper and we'll do a little bit of math now. For outpatient hospitals, for example, if you have 360,000 Medicare paid services in 2007, Medicare paid services in 2007, divide that by 12, it'll give you an average of approximately 30,000 Medicare paid services per month. Multiply that by 1% and you get 300 medical records.

Now, of course, the limit is 200 records per 45 days and we will - the RACs will not go over that 200 record limit, so you've hit the max and you will get - you can potentially get a request for 200 medical records. Again, as Ebony pointed out, one of CMS’s primary goals for this program is to minimize provider burden and part of the way we’re going to do that is try to ensure the accuracy of the RAC’s decision.

Each RAC is going to employ certified coders, nurses and/or therapists, and will have a physician contractor-medical director on staff. Now, that’s different than the demonstration where it wasn't required for the RAC to have the CMD on staff, although some of them did opt to do that.

Going forward, in the national program, they will be required to do that. Also, as Ebony mentioned, CMS will have a new issue review board, which will provide greater oversight of RAC activities. We will have a RAC validation contractor, which will pull a sample of RAC claims, look at them and check their accuracy. They will provide an annual accuracy score for each RAC that will be made public.

And one of the biggest changes, from the demonstration, and one of the things we think is going to help the most to ensure accuracy is, if a RAC loses at any level of appeal, the RAC must return the contingency fee.

During the demonstration, I think it was the first level of appeal, if they lost, they still retained the contingency fee. If they lose at any level of appeal now, they must return the contingency fee, which we think is great incentive for the RACs to check their work, double check their work.

We also want to maximize transparency of the program. This is very important. Connie Leonard and Marie Casey have instructed us to make sure that the provider community knows what's going on here.

New issues, once they're approved by CMS, will be posted to the respective RAC Web sites. Once they become operational, which I think just about everybody (unintelligible). Am I correct with that or - okay.

All of our vulnerabilities are also going to be posted to the Web and, by January 1, 2010, the RACs will be required to have a claims status

Web site where a provider can go in and check on the status of a claim under review.

You will also be able to check to make sure the RACs have received medical records, once you send them forward. We think this will be a very helpful tool, once it's up and running.

Again, from the beginning, the RACs will be required to have a basic Web site up, to post the new issues, but January 1, 2010, they're expected to have the claim status Web site available.

Also, the RACs will be sending forward detailed review results letters following all complex reviews. The detailed review results letters will give you an opportunity to see exactly why the RACs have - are denying the claim and will also kick off the discussion period, which will allow you to call the RAC.

And we encourage you to do that, if you disagree with RAC findings, and discuss with the RACs why you disagree and it gives you a chance to possibly speak to the medical director, and that's the discussion period, which we'll talk about a little more here in a second.

The new issue review process for automated claims will work like this:

The RAC will send any new issues to CMS to review. The new issue board will consist of policy folks, it will consist of a medical director, clinicians, nurses, they will review all of the information that the RACs send forward, and CMS will decide whether or not there is a legitimate issue.

If so, they will let the RAC know. They'll review and decide. If the issue is approved, it's posted to the RAC Web site and the RAC may

then begin wide-spread review. All demand letters are sent, after CMS has approved the new issue for review.

Now, for complex reviews, the RAC will issue a limited number of medical record requests to providers. That is - I use sample. Marie, do you have another word for that?

Like a ten claim sample that you may possibly receive and, once the RACs send that out and get the claims back, they will use that to determine - or in part to determine whether or not they want to pursue this issue any further.

The providers will send medical records in return, the RAC will review the medical records, and then the RAC will send the new issue review request to CMS, if they determine they want to move forward with it.

Again, CMS will review the new issue and decide whether or not it's legitimate and, if it's approved, the issue will be posted to the RAC Web site and the RAC may begin wide-spread review.

In cases, where CMS has not - CMS has 60 days to decide whether or not they are going to approve the issue. In cases where CMS has not decided by day 60, the RAC can issue a limited number of review result letters, without CMS approval and Web noticing.

Okay, so what can you, as a provider, do to get ready for a RAC review. Well, look at what the RACs are looking at.

Know where previous and proper payments have been found, perform internal audit, look at your billing patterns, if you see aberrancies, know if you're submitting claims with improper payments.

Prepare to respond to RAC medical record requests. That's important. Once you get the medical record request, you have 45 days to send those medical records forward.

So be aware of that. Make sure you have somebody on staff that is tracking the RAC requests. You could set up an internal system to do that, but until January 1, 2010, we would recommend that you, you know, when the RACs would have the claim status Web sites up we definitely encourage you to have some kind of internal tracking.

Look and see what improper payments were found by the RAC. You can look on the demonstration finding on www.cms.hhs.gov/rac. The RAC permanent findings will be listed on the respective RACs Web site.

You may also want to check the OIG and Cert report. The OIG reports are listed on www.oig.hhs.gov/report.html.

And Cert reports are listed on www.cms.hhs.gov/cert. Again, look at what the RACs are looking at. Know if you're submitting claims with improper payments. Conduct an internal assessment to identify if you are in compliance with Medicare rules.

Once you've done your internal assessment, identify corrective actions to implement for compliance. Prepare to respond to RAC medical record requests, as we just discussed.

Tell your RAC the precise address and contact person they should use when sending medical record requests records letters.

Call the RAC to make sure that they have received your medical record. And no later than January 1, 2010 you can use the RAC Web site. When necessary, check on the status of your medical record. Did the RAC receive it?

Again, call the RAC and talk to them about it. Appeal when necessary. The appeal process for RAC denials is the same as the appeal process for carrier, FI or MAC denials.

Do not, however, confuse the RAC discussion period with the appeals process. If you disagree with the RAC determination, don't stop by just sending a discussion letter.

Again, we encourage you to call the RAC and remember to file the appeal before the 120th day after the date of demand letter. Okay, the RAC determination process.

The RAC decides whether medical records are required to make determination. For an automated review, of course, they will not be requesting medical records. The RAC will make the claim determination. They will send the overpayment demand letter, and you will also receive the remittance advice notice from the FI.

The remittance advise notice will have a code, N, as in Nancy, 432. That code will indicate that the determination was made based on a RAC audit. In cases of a complex review, the RAC will again request medical records.

The provider will submit the medical records and has up to 45 days plus 10 calendar days to respond. The RAC then has up to 60 days to review the medical record and make a claim determination. The RAC issues a review results letter to the provider.

The review results letter will not communicate the amount of the overpayment or the appeals right. If there is no finding, the process will stop right there. The RAC will send claims information to the carrier, the FI or the MAC for adjustment.

The carrier, FI or MAC will adjust and issue the remittance advice, again with the code N432. And the RAC will issue a demand letter which includes the amount and the appeals right.

The remittance advice notice and the demand letter should come at roughly about the same time. On day 41, the carrier, the FI or MAC will begin recouping by offset, if a valid appeal is not filed or payment is not made.

One of the things we've done at CMS is learn from the demonstration. Lessons learned. We've used these lessons learned to try to help minimize the provider burden with the national program.

We encourage you to do the same thing. Learn from your past experiences. Keep track of your denied claims.

Again, look for patterns in your billing, patterns of aberrancy and determine what corrective actions you need to take to avoid improper payment. I'd like to give you some contact information now.

One of the Web sites I've already given you is www.cms.hhs.gov/rac. I would highly encourage you to go in very often to this Web site. We will be posting updates to the program and other interesting information on there. You can also email the RAC team at rac@cms.hhs.gov.

We have project officers, which are your RAC contacts for each respective RAC. In Region A. That person is Ebony Brandon. Her number is 410-786-1585.

In Region B, the contact person is me, Scott, at 410-786-4301. For Region C the contact person is Amy Reese at 410-786-8627. And for Region D it is Kathleen Wallace, 410-786-1534, that's 410-786-1534.

Please feel free to contact any of us at any time if you have any questions or any problems in your respective RAC region. At this point I will turn it back over to Marie Casey and let her add to that.

Marie Casey: Actually, I have nothing to add. You can probably open up the call for questions.

Natalie Highsmith: Okay. (Stephanie) if you could just remind everyone on how to get into the queue to ask their questions. And everyone please remember when it is your turn, to restate your name, what state you are calling from, what provider or organization you are representing today.

And also if you have more than one question, we ask that you start with just stating your first question and go back into the queue to ask your second question or save any further comments you may have so we can move quickly through the Q and A. (Stephanie)?

Operator: At this time if there are any questions, please press star and the number 1 on your telephone keypad. Your first question is from Karen Brown from South Carolina. Your line is open.

Karen Brown: Hello, Scott. This is Karen Brown calling from South Carolina (unintelligible) Regional Medical Center. You mentioned that record requests that we had 45 days plus 10 calendar days to return the medical record. Did I understand that correctly?

Scott Wakefield: That is correct, Karen. We give the additional days for mailing time. We're aware that in some of the rural regions sometimes the records, the U.S. postal service doesn't exactly get them to you in a timely fashion.

Karen Brown: Thank you.

Scott Wakefield: Sure.

Operator: Next question is from (Mindy Stanelle) from Wisconsin. Your line is open.

(Mindy Stanelle): I just wanted to clarify, in terms of the limit, when you talked about outpatient hospital and a limit of 200, that would be a limit of 200 for both inpatient and outpatient? Or 200 for each?

Marie Casey: The 200 limit would be for - based on if you have a sizable Medicare claims volume, you would hit that max limit of 200 for your Part A inpatient claims. If you also have hospitalists on staff, which may bill Part B of the program, you then may also incur whatever the medical record limit is for the Part B services per 45 days.

(Mindy Stanelle): All right. Thank you.

Marie Casey: You're welcome.

Operator: Next question is from (June Wang) from Indiana. Your line is open. Ms. (Wang), your line is open.

(Marie): Hi, this is (Marie). I'm working with (June). You've mentioned the RAC discussion more than once. But you haven't mentioned the rebuttal. Are those the same thing?

Ebony Brandon: (Marie), we called it the rebuttal period in the demonstration but in the permanent program, we're calling it the discussion period. I think some people were confused by calling it the rebuttal process in the demo. So we have changed it. So basically, yes it's the same.

(Marie): Same thing. And I can't find a lot of material about that and the relationship between the rebuttal and the start of the appeal process. I know they're not the same thing. But when we were educating ourselves, the rebuttal it said would stop the recoupment. Is that true?

Ebony Brandon: If you - the discussion period will actually begin for automated review, it starts with the date of the demand letter. Once you get that demand letter from the RAC, you're discussion period begins.

You can pick up the phone and call the RAC and say, you know, hey I think you're wrong. I have more information to support that. And they will take that information. The sooner you get in, then the better.

If they decide that, you know, you're correct and they agree with you, they are able to stop that adjustment and stop you from having to even go through the appeal.

And then on the complex side, it starts with the date of the review results letter. Same thing, you pick up the phone, you know, justify why and if it's done timely, you will be able to stop the adjustment.

(Marie): So you make it sound like that's more of a conversation as opposed to a letter that I would write. Is that true?

Ebony Brandon: Well you - so we say you can pick up the phone and call them and say hey, I want to discuss and I have more information. That can start the discussion period. And then of course, you would send a letter with supporting documentation.

(Marie): But your recommendation is that it's not that you would do a discussion in lieu of appealing. You would want to do both.

Ebony Brandon: We tell you that the discussion period does not take away your appeal right. If you think you're going to appeal, we tell you to file that appeal because you can possibly, you know, risk having your funds recouped. But if you're sure that the RAC is wrong and you have documentation to support that, we want you to use the discussion period.

Natalie Highsmith: I'm sorry, (Marie), we do have to move onto the next question.

(Marie): Thank you.

Natalie Highsmith: Next question please.

Operator: The next question is from (Betty Breshears) from Missouri. Your line is open.

(Betty Breshears): You had mentioned that you thought all of the RAC - yeah, the RACs had their Web sites up. Are we looking for those Web sites on the RAC Web site or are we looking on CMS' Web site for the individual section on our RAC?

We can't find anything.

Ebony Brandon: (Betty), once the RACs have notified us that the basic Web site is up and ready, we're going to post those links to our CMS Web site. Some of the RACs have started conducting - provide an outreach and may have given that Web site out during those sessions, but right now I don't believe you'll be able to find that from the CMS Web site.

If the RACs on the phone and your Web site is live, you can give that now. Is DCS or HDI and CGI on the phone?

(Mary Hoffman): Yes, CGI is on the phone. This is (Mary Hoffman) and our RAC Web site is http://racb.cgi.com.

(Katherine Hill): This is (Katherine Hill) from DCS and our Web site is www.dcsrac.com.

Lane Edenburn: And this Health Data Insights. Our site is just about up and ready to go. In the interim, if there are questions, we do have an email address available, and that is racinfo@emailhdi.com.

Ebony Brandon: Connolly, are you on the line?

Christine Castelli: Yes, I am. This is Christine Castelli from Connolly Healthcare and currently right now our site will be going live any day. However, you may reach us at, of course, www.connolly -- C-O-N-N-O-L-L-Y -- healthcare -- all one word -- .com.

Ebony Brandon: Thank you.

Christine Castelli: You're welcome.

Natalie Highsmith: Next question, please.

Operator: The next question is from (Amelia Ng) from New York. Your line is open.

(Amelia Ng): Can you hear me?

Natalie Highsmith: Yes, we can.

(Amelia Ng): Hello, can you hear me?

Natalie Highsmith: Yes, we can.

(Amelia Ng): Oh, okay. In the past - I think I want to clarify something.

If let's say that you send us a letter with 40 medical record requests, you know, we provide those medical requests to you and you do your analysis, what if you find problems with three of those medical records? Would you - and none - no problems with the rest of 37.

Would you be sending a confirmation or an answer regarding the full letter, meaning that you will say, you know, three cases we have an issue and this the take back or whatever? And so the rest of the 37 there's no issue, you can close the file.

Because I think in the past we've had issues kind of - and difficulties reconciling the full, I guess, project or the full letter or request, and I'd like to know you think - you were thinking about handling that or the RACs would be handling that.

Marie Casey: (Amelia), yes. And the permit program they will issue a results letter for each medical record. If there are no findings, you would get a letter stating there are no findings.

(Amelia Ng): And if there are findings, what would you be stating?

Marie Casey: They're going to ask - they'll go into more detail in the letters than they did in the demonstration.

(Amelia Ng): Okay.

Ebony Brandon: They will tell you, you know, the amount, give you your appeal rights, tell you why it was denied and, you know, any - direct you to any sources or CMS policies that were violated.

(Amelia Ng): Oh, okay. Yeah, because I think one thing that we found that we didn't really, really liked in the past is that let's say you get a medical record request and, you know, you send it in and there's an issue that they found regarding one charge, right?

What they would do is then they would send a second letter saying, you know, we found issues with, I don't know, charge XYZ, but they will not reference the fact that they found it in the medical record request. So it looks like this is a new request, but it really wasn't. It was part of the medical record request.

And so we really couldn't track it back to that original request.

Ebony Brandon: Yeah, just…

(Amelia Ng): So we just want to make sure that, you know, that you consider that when you're submitting, you know, the letters to us.

Ebony Brandon: Yes, we have. Thank you.

(Amelia Ng): Okay, thank you.

Operator: The next question is from (Veronica Gandia) from Texas. Your line is open.

(Janie Vargas): Yes. I'm (Janie Vargas). I'm a nurse auditor for the Compliance Department here at Thomason Hospital and one of my questions is that we have been - for the State of Texas we're under Region C and I would like to ask what's the projected outreach date for the State of Texas.

Ebony Brandon: The project officer for Region C is not here, but we think that it's May.

Woman: It's May 20.

Christine Castelli: This is Christine from Connolly. May I answer that, please?

Ebony Brandon: Sure. Go ahead, Christine.

Christine Castelli: Yeah, hi, this is Christine Castelli from Connolly Healthcare. We have three sessions planned - I'm sorry, two sessions planned. One of which will be planned on - for the May 13 date. We will be doing, I believe, the hospital Association in the morning, the Medical Society in the evening, and as well as on May 14.

We will be in San Antonio - May 13 we're in Dallas and on the 14th, San Antonio and then on the 15th, Houston; same cycle.

Does that answer your question?

(Janie Vargas): Yes, thank you. Are we going to receive any type of email or anything giving us the agenda or the dates or the place where you guys are meeting?

Christine Castelli: I would - for the sake of the rest of the callers please feel free to contact me directly and I can help you out with that and in addition to that please go to and visit your hospital association as well as your medical society's Web site, but please feel free to contact me directly.

(Jane Vargas): Can you give me your number once again because I was unable - it was said too fast, your contact number.

Christine Castelli: I will give you my toll free. It's area code 866-360-2507 extension 2315.

Ebony Brandon: In addition...

(Jane Vargas): Thank you.

Ebony Brandon: In addition on the CMS Web site we have posted the provider outreach schedule. That will be updated as new sessions are scheduled, so you can view that at cms.hhs.gov/rac.

Natalie Highsmith: Next question, please.

Operator: Your next question is from (Dina Swartz) from Texas. Your line is open.

(Ray): Yes, this is (Ray) (unintelligible). I was calling; one could get information on which medical necessity criteria the RACs we'll be using for (ELPAC)?

Ebony Brandon: Well, they have to use CMS, you know, policies and Medicare policies and manuals. If you mean just screening tools, of course, we want you to know that that can't be used, you know, to pay or deny a claim.

But as far as the ones that they've chosen to use I'll let the RAC answer that.

(Ray): All right, thank you.

Operator: Your next question is from (Carol Kendall) from North Carolina. Your line is open.

Natalie Highsmith: Can you hold on one second, (Stephanie). We were still answering the previous question.

Ebony Brandon: DCS, do you want to answer?

(Katherine Hill): We have not yet decided between InterQual or Milliman. We're evaluating both but, as Ebony said, we would be utilizing Medicare policies, LCDs and NCDs in order to conduct our audits.

Ebony Brandon: CGI?

Mary Hoffman: Yes, CGI will utilize the criteria that the FIs are currently using for the region. So far for two regions it's InterQual.

Ebony Brandon: HDI?

Lane Edenburn: Hi, this is (Lane Edenburn). I'm medical director for HDI. We follow CMS guidelines which are that these different products are guidelines. They're not conclusive for a decision to or for a finding or not a finding.

We have contracts with both Milliman and InterQual and intend to use those along with clinical review judgment and, of course, first and foremost the CMS guidelines.

Ebony Brandon: Connolly?

Christine Castelli: This is Connolly. We have not yet made our decision. However, we will also be utilizing the same tools that all of the folks on the line have previously stated as well as our own interpretation in working side by side with CMS.

Natalie Highsmith: Thank you. Okay, (Stephanie), we can proceed.

Operator: I apologize for that. (Carol Kendall) from North Carolina, your line is open.

(Carol Kendall): Hello, this is (Carol Kendall) from Highpoint Regional Health System in Highpoint, North Carolina. You've talked about the use of the word service when you are sampling for outpatient record reviews.

Could you explain if there is a difference between the word service and the word claim as it relates to record selection?

Ebony Brandon: Yes, (Carol), when we say services we're referring to the claim line and when we say we're, you know, for the other one we're talking about the actual claim. So claim line versus claim.

(Carol Kendall): Now, by again claim line do you mean paid claim lines for example APC lines or - I guess I need a little bit more understanding of what even then you mean by claim lines.

Ebony Brandon: Yes, this is all - we're talking about paid claims.

(Carol Kendall): Yes.

Ebony Brandon: The (unintelligible) of paid lines and paid claims.

(Carol Kendall): But one claim could have multiple claim lines each of which were paid, so is it based on that information, for example, if one claim has ten different paid claim lines that is equal to ten services?

Ebony Brandon: Yes. Does that answer your question, (Carol), or if you need more detail the person that actually, you know came up with the medical

record limits and worked closely in that area is not here. You can always email that question and we can get clarification for you.

(Carol Kendall): Okay, thank you.

Ebony Brandon: You're welcome.

Operator: Your next question is from (Lynette Barrera) from Texas. Your line is open.

(Patricia Fleming): Yes, this is (Patricia Fleming) from Odessa. I'm concerned about the 45 days after we receive the names of the cases. During those 45 days if we see an error whether in our favor or yours do we still have time to re-bill that if it's within the Medicare re-billing (date)?

Ebony Brandon: That, (Patricia) - are you referring to re-billing for the ancillary charges?

(Patricia Fleming): I'm referring to the whole charge during those 45 days that I have to send them to you, during those 45 days if I find an error on one of those charges can I re-bill it at that moment or do I have to wait until it's audited?

Ebony Brandon: No, you would have to wait for the RAC decision and for it to be adjusted.

(Patricia Fleming): Okay, what I'm referring to is prior to the audit.

Ebony Brandon: If you mean prior to receiving any request from a RAC and you do your own self-analysis.

(Patricia Fleming): Oh, during those 45 days after I receive the demand letter do I have any right to re-bill that prior to your audit on that particular case if there's any?

Scott Wakefield: Well, I think the terminology is getting real confuse because the audit is the actual RAC review of the data which leads to them sending you the medical record, or the medical record request.

So are we getting the terminology confused?

(Patricia Fleming): So once I receive that demand letter you have already looked through that case?

Ebony Brandon: Correct.

(Patricia Fleming): Okay, thank you. That answers my question.

Ebony Brandon: Okay, you're welcome.

Operator: Your next question is from (Michelle Wong) from New York). Your line is open.

(Michelle Wong): Hi, can you tell me if the RAC doesn't get back to us in 60 days after we send the medical record can we consider the case closed?

Ebony Brandon: No, you will receive notification from the RAC. In rare instances, the RAC may not get back within the 60 days but they have to have approval from the CMS project officer, and in that case they would contact you saying we have received approval from CMS and we - it may take longer than 60 days but those will be rare cases.

Scott Wakefield: And, (Michelle), that leads us to another point, too. If within the 45 days of receiving the medical record request, if you're having problems getting that information together please contact the RAC and let them know because they are willing to work with you to maybe, possibly extend that if you need the additional time.

(Michelle Wong): No, I understand that. I was saying once the RAC has the record that they have 60 days, but now I think I'm hearing that the RAC can be given an extension if approved by CMS.

Ebony Brandon: Correct.

(Michelle Wong): Thank you.

Operator: Your next question is from (Diane Gilmer) from Ohio. Your line is open.

(Diane Gilmer): Hi, we are obviously in Region B and I still need some clarification about the number of medical records that are going to be requested. For example, there was some reference to the number based upon the NPI number annual volume.

So let's say, for example, a corporation has a skilled nursing facility, a home health agency and a hospice agency all under the same NPI. How do we know what kind of record request we may expect based upon that NPI?

Scott Wakefield: If it's under one NPI then the number of medical records you could have requested...

(Diane Gilmer): Is there a maximum?

Scott Wakefield: Yes, I'm sorry, is a maximum of 200 if all those - because it's not by service. It's by NPI.

Ebony Brandon: So basically if you - you all - you have the same NPI and it's 10% of the average monthly Medicare claim so the take 10% of that. It's up to the RAC at the time and if they want to do 50, 50 and 50 (unintelligible) if they can determine, you know, how they want to request those records, but the max is 200.

(Diane Gilmer): Okay.

Marie Casey: And the thought process behind this process - this is Marie Casey speaking, is that we did not want to overwhelm a medical records room that may have medical records for all of those different provider types for SNF, inpatient and inpatient rehab for, you know, possibly, you know, the other party and patient services.

We do not want to overwhelm that medical records department with 200 per claim type. So that's why we've put these medical records in place.

And we're testing it this year, and we'll see how it works. We do know there's a lot of different circumstances out there with the use of NPI.

So what we're telling providers is, "We'll work with you to come up with reasonable medical record limits based on your facility, your medical records department and the volume of claims that you bill the Medicare program.

And they will identify for you on that medical records request letter what your limit is and then you can contact them with that information if you have issues.

Scott Wakefield: We also plan on having the RAC list, the medical record limit on your first request for medical records. So that number should be on the letter.

Diane Gilmer: Okay, and Scott could you go over the phone numbers to contact you guys at CMS it was pretty quick and I'm not sure...

Scott Wakefield: Sure, why did you - you're in Region B, right?

Diane Gilmer: Right.

Scott Wakefield: Just call me then, 410-786-4301, or you can email me so we can have a paper trail.

Diane Gilmer: Okay.

Scott Wakefield: scott.wakefield@cms.hhs.gov

Diane Gilmer: Okay, thanks.

Scott Wakefield: Sure.

Natalie Highsmith: Next question, please.

Operator: Next question is from (Kathy Roberts) from Texas. Your line is open.

(Kathy Roberts): Yes, I have two questions. The first question is, “At what point will you accept the CD with the medical records versus hard copies? Is that immediate?”

Ebony Brandon: Yes.

(Kathy Roberts): Okay. All right. The second question is we’re in Texas and I hear the date is in May for the outreach, provider outreach. Will the records request under RAC start before we’ve had the provider outreach training?

Ebony Brandon: No.

(Kathy Roberts): So the earliest we would get requests for records would be after that May 15 or so deadline?

Ebony Brandon: That is correct.

(Kathy Roberts): Okay, thank you.

Operator: Next question is from (Mary Martin) from Ohio. Your line is open.

(Mary Martin): Hi, this is (Mary Martin) with Humility Mary Health Partners in Youngstown, Ohio. I have four questions. And I promise I will be quick with them. I am wondering if CGI will accept an email zip file, password protected, for medical records.

Ebony Brandon: No.

(Mary Martin): No, okay. And then how do we go about confirming who you have as the main contact person and address for our facilities?

Ebony Brandon: All the RACs have address customization. Some partly have forms available on their Web sites. If they don't, you can pick up the phone and call them and they will take that contact information, phone number and address.

(Mary Martin): Okay, and is CGI able to share the outreach dates yet for Ohio?

Scott Wakefield: They are currently on the Web site, at the CMS Web site.

(Mary Martin): I just looked and they're not there yet.

Scott Wakefield: Well, then if they're not on there, we don't have anything scheduled yet. And Ohio is what we call a second wave state. Starting August 1, 2009, probably later in the month we will start doing the outreach in the second wave states. So you can look for something probably around then.

(Mary Martin): Okay, and then my last question is CGI mentioned that they had confirmed what criteria screening tool they were using for two of their states. Can they tell us what they are using for Ohio?

Scott Wakefield: If it is there at this time...

(Mary Martin): No? Okay, thank you.

Operator: Your next question is from (Wanda O'Neil Glass) from Texas. Your line is open.

(Wanda Glass): Hi, my name is (Wanda). I'm from Metroplex here in Kemah, Texas. My question is on the (automative) types of (demounts) that you're doing, are those edits that are set in?

Ebony Brandon: Yes.

(Wanda Glass): Thank you.

Ebony Brandon: You're welcome.

Operator: Next question is from (Karen Brown) from South Carolina. Your line is open.

(Karen Brown): Hello again. I just wanted to clarify because there's been some discussion about this medical record review number. NPI versus tax id, if you've got one, an organization that has several entities under, but they are billing under the tax id versus each entity has the NPI, what are you going to be basing the medical records limit on?

Ebony Brandon: I'm sorry. (Karen) can you send me an email because your situation may be unique? Send it to the rac@cms.hhs.gov. That's the email address.

(Karen Brown): Okay, and the second question is if the RAC representative can repeat their Web site addresses for their RAC. I think I missed some of the letters.

Ebony Brandon: Sure.

(Karen Brown): Thank you.

Ebony Brandon: DCS...Is DCS on the line?

Cathy Hill: You wanted the Web site address?

Karen Brown: Yes.

Cathy Hill: It's www.dcsrac.com.

Ebony Brandon: Thank you. Connolly?

Christine Castelli: www.connollyhealthcare.com

Ebony Brandon: Thank you. HDI?

Lane Edenburn: HDI's Web site should be live any day now but in the interim, you can email questions to racinfo@emailhdi.com.

Ebony Brandon: Thank you. And CGI?

Mary Hoffman: http:\\racb.cgi.com

Ebony Brandon: Thank you and we will post the information to our Web site. If you would like to receive RAC email updates, you'll get a notification that our page has been updated.

Natalie Highsmith: Next question please.

Operator: Next question is from (Bobby Diamond) from California. Your line is open.

(Bobbie Diamond): Hi, thank you. I wanted to ask if - I know that - is RAC going to be communicating with all of the facilities or are they going to pick and choose?

Ebony Brandon: Do you mean in reference to being audited?

(Bobbie Diamond): Yes.

Ebony Brandon: If they identify improper payment, you know, for your facility then you'll hear from the RAC. If they don't find anything, then you will never hear from the RAC.

(Bobbie Diamond): Okay, so it's not going to be 100% of the facilities are going to be audited?

Ebony Brandon: Correct.

(Bobbie Diamond): Okay, thank you.

Ebony Brandon: You're welcome.

Operator: Next question is from (Charlene Allen) from Tennessee. Your line is open.

(Charlene Allen): Hello, this is (Charlene Allen) with Life Care Center. We are a chain provider with over 200 facilities across the country and we are a (1FI). Then of course we will be with (1 MAC) in the fall.

So our question is will the facilities be reviewed from the jurisdiction of where our corporation is located, where our FI is located? Or will they be reviewed according to what state each facility is located in?

Ebony Brandon: Charlene, we're working on chain providers FAQs because there's so much involved in that. Can you email that question to the email address and I'll get you an answer.

And once we get those FAQs developed, we're going to post those to our Web site.

(Charlene Allen): Certainly, I'll do that.

Ebony Brandon: Thank you.

Operator: Your next question is from (Angie Harbour) from California. Your line is open.

(Angie Harbour): Hi, this is Angie from Loma Linda University Behavioral Medicine Center. My question is we're a psychiatric facility, free standing. How will we be affected? Will we be affected?

Ebony Brandon: If you bill fee for service Medicare, then your claims are subject to RAC review.

(Angie Harbour): Okay, we are billing and well actually we're getting paid through the IPFPPS, Inpatient Psychiatric Facility Prospective Payment System.

Ebony Brandon: Then yes your claims are subject to RAC review.

(Angie Harbur): Okay. Thank you.

Operator: Your next question is from (Stewart Presser) from New York. Your line is open.

(Stewart Presser): Hi guys. I think you should provide more clarity to the listeners concerning how the sample of 10 records is going to be obtained within a state. It was just stated, I think by Scott, that the RACs can get a sample of 10 records.

And we've discussed this many times. And there really doesn't seem to be a clear-cut answer as to how this is going to work.

Ebony Brandon: Sure. The RAC has to go out and request a sample of medical records in order to do that data analysis and send the new issue proposals to CMS. That's up to ten claims.

Those claims can come from a single provider or they can come from, you know, multiple providers, to, you know, from one facility, two from another, three. So it will vary depending on the RAC.

(Stewart Presser): Okay. Also, I think we've discussed in the past that the letters requesting sample records will indicate that this is a sample request?

Ebony Brandon: That is correct. The letters - that initial letter, you will be able to tell that it's a sample request and it's not a widespread, approved CMS issue.

(Stewart Presser): Okay.

Operator: Next question is from Cindy Gilbert from Illinois. Your line is open.

Cindy Gilbert: Hi. You've pretty much kind of answered my question already, but just for a point of clarification, I belong to a health system that is bi-state. And obviously, they are states that are involved in different RACs.

So you're telling me - or I understood you to say - that we would need to - you're coming up with an answer for that scenario so that we could report through one RAC rather than two?

Ebony Brandon: That's correct.

Cindy Gilbert: Okay.

Operator: Next question is from Ena Niemand from New Mexico. Your line is open.

Ena Niemand: We are in a freestanding in-patient rehab facility, and I'd like some clarification on the rolling 45 days that refers to the amount of 10% charts that can be requested.

Ebony Brandon: They can request up to 45 - I'm sorry, the medical records every 45 days. And when we say every 45 days, we're referring to calendar day.

Ena Niemand: So just for clarification, I can divide the year into 45 day segments and determine how many charts I'm going to have put into my discharge from CMS?

Ebony Brandon: The first was eight, we'll start there 45 days. So it's whatever they make it for. Lori?

Lori Wiggins: Hi. My understanding - and, you know, this is a process that's in flux - is that when you get the first medical record request, the date of that medical record request, you should not receive another medical record request within the next 45 days.

So there are not set 45-day windows throughout the country. It's going to vary depending on the facility that's receiving the request. Does that answer your question?

Ena Niemand: That answers the question. I have a second question. We had our educational opportunity in November from Connolly. Will they be doing any more in New Mexico?

Ebony Brandon: Christine?

Christine Castelli: This is Christine from Connolly. We are in discussions currently right now to possibly do a revisit sometime in June to New Mexico, however we are currently right now working with the association to see whether or not that is something that they are interested in doing. But as of right now we do not have anything set on our schedule.

Ena Niemand: Thank you very much.

Operator: Next question is from Betty Overman from Indiana. Your line is open.

Betty Overman: Thank you. This is Betty from St. Francis, and my question is, is there a list of CMS entities that cannot request a RAC record? And are the RAC cannot request the record if the entity has already been reviewed? If that record has already been reviewed by another entity? Is there any kind of a list?

Ebony Brandon: No, we don't have a list, but what we do have is the data warehouse. And that will ensure that the record, instead of being reviewed by another Medicare entity, it will be excluded from RAC review.

Scott Wakefield: The RAC data warehouse, if I may (tail) onto that a little bit. The RAC did a warehouse that has suppression and exclusion functions where an outside identity, whether it be law enforcement, a MAC, an FI or a carrier, a QIO, or even insert claims into the RAC data warehouse, which will prohibit the RACs from going after those specific claims.

Betty Overman: Okay. One other question while we're here. In terms of refunding the money to Medicare, will that usually be recoupment or by check, or is that up to the hospital facilities?

Ebony Brandon: That's up to the facility.

Betty Overman: Okay, thank you.

Ebony Brandon: You're welcome.

Operator: Next question is from Ann Edwards from Massachusetts. Your line is open.

Ann Edwards: Hi. I have a couple questions for you. One is about the rebuttal process for the automated claims. What is our rebuttal process?

Ebony Brandon: The discussion period, once you receive the demand letter, that's your opportunity to discuss with the RAC if you have supporting documentation or if you just want to call them, you know, to get (proper applications), once you get that demand letter, that's your opportunity to have that discussion.

Ann Edwards: All right. Thank you. Another thing is, we have diversified. Do you know or anticipate when we will be hearing from them?

Ebony Brandon: Massachusetts is now a blue state - well, it's not a blue state. Because of the MAC transition we have a blackout period in Massachusetts, so you're now scheduled for August 1, 2009 or later.

We anticipate conducting outreach maybe sometime this summer, but we have not set a date yet.

Ann Edwards: All right. Thank you. (unintelligible)just one more question. Are we having two different start dates - one for Part A and one for Part B?

Ebony Brandon: Part B does not have a blackout period, so it's possible that review of Part B can begin prior to Part A. But again, the provider outreach will be conducted before that happens.

Ann Edwards: All right. Thank you so much.

Ebony Brandon: You're welcome.

Operator: Next question is from Penelope Wilkins from Georgia. Your line is open.

Penelope Wilkins: Yes, I have a question for the CMS officials. How will they determine if a new issue is approved to be put on the list? They said they have to be approved, and I'm trying to understand what your criteria to approve an item is.

Ebony Brandon: CMS will review what their new issue is. They have to, you know, send what the issue is, why they feel it's a problem, are there any Medicare policy that is violated. And then it will go before the board.

The board will then look at that issue and, like we said, policy people will be on, you know, on that board, and they will determine if they agree with the RAC. Has an actual Medicare policy been, you know, violated?

So it depends on what the issue is, the LCD the NCD. They look at all of that.

Scott Wakefield: And again, once the board approves the issue - if they approve it - the RAC can then go forward with a widespread review.

Marie Casey: And just to clarify, the CMS board is composed of component leads such as our CMM staff, which are our policymakers here at CMS.

Our coverage analysis group that work on our national coverage determinations, we have a representative from appeals staff, as well as our office financial management staff.

They all sit on that board and decide whether they believe that it is a good issue for a RAC to pursue on a widespread basis.

Penelope Wilkins: And is that what the ten sample claims are for?

Ebony Brandon: Yes. The ten sample claims helps us to see if truly, you know, based on the clinical situation of the patient, does looking at that issue make sense?

We wanted to not just look at what the rules are, but we wanted to actually see clinical examples and see the type of documentation that was out there before the agency felt comfortable, especially going forward with the complex reviews.

The automated reviews, we have not required necessarily a RAC to get a medical record. However, we have seen some instances where if a RAC has any doubt whether their issue should be an automated or a complex, we are recommending that they actually do some complex reviews first.

We did have some problems in the demonstration where, you know, we had an issue with looking at lesions, and whether those lesions were - there was many billed, but indeed, in some of the cases, the medical record did identify that those lesions were reasonable and necessary.

So an automated (ED) just to deny over a certain number would not be appropriate. And therefore, we would never have known that unless we did complex review.

So those are the types of things we want the RACs to make sure that they also request medical records for, before submitting them to CMS.

Scott Wakefield: But to add onto that, the ten-claim probe is not the sole determining factor in whether or not an issue will be approved. It's just mitigating information.

Ebony Brandon: That is correct. We may have ten claims but only have three improper payments in that claim sample that we may receive. However the issue itself is a valid reason for the agency to pursue it on the widespread basis. The policy is sound. Those are the type of things we're looking for.

Penelope Wilkins: Okay I think I understand, thank you.

Ebony Brandon: You're welcome.

Operator: Next question is from (Linda Hogel) from Ohio. Your line is open.

(Linda Hogel): Hi, this is (Linda Hogel) from Ohio. I've got a question about this discussion period. When we receive a demand letter and we identify something that we think is an error on the RAC's part and we initiate a discussion period does, do the 45 days start counting at that point as well for appeal?

Ebony Brandon: No well it's not 45 days I think (unintelligible) some of the dates have gotten confused from the, we don't really have a timeframe for the discussion period.

Once you get that demand letter that starts the discussion period but yes, you are correct that in order to prevent your funds from being recouped due to Section 935 that actually, I'm sorry, let me go back.

The automated review the discussion period begins with the date of the demand letter. And you pick up the phone you call the RAC and start that discussion period. That's why we say, you know, if you want to appeal then do it right away because you are correct it's the

((Crosstalk))

Ebony Brandon: And for the complex it starts with the date of the review results letter. However the clock will not start clicking towards the appeal until the date of the demand letter. So you actually have more time there.

(Linda Hogel): Say that again now.

Ebony Brandon: For complex the discussion period you'll, initially you'll get a review results letter stating an overpayment has been identified and, you know, here is the results.

That will actually start the discussion period for complex because that, you'll get a review results letter in addition to a demand letter for complex review. So you have more time for complex review for discussion.

(Linda Hogel): Okay that makes sense.

Scott Wakefield: The important thing to keep in mind I think is that the process really doesn't vary that much from what you're used with the FIs, the carriers and the MACs. The only difference being as everybody pointed out earlier the demand letter will come from the RAC.

So the periods are pretty much the same. The discussion period is an informal period. It doesn't stop the process from flowing forward. So that's something you want to keep in mind.

(Linda Hogel): What's the usual turnaround time for the discussion period, I mean....

Scott Wakefield: There is none, it's, you know, I really think it's dependent on the provider. If you get the review results letter in a complex review and you call, you know, you call the RAC and want to talk to them about it that's all pretty much done on your timeframe.

If you decide that you don't have an issue with it or you decide on day 43 that you're going to call them, you know, that's pretty much

dependent on you. So that's why CMS encourages you if you do have an issue to call as soon as possible.

Ebony Brandon: Does that answer your question?

(Linda Hogel): Yes, thank you.

Ebony Brandon: You're welcome.

Operator: The next question is from (Cherry Clavette-Arnold) from New Hampshire. Your line is open.

(Cherry Clavette-Arnold): Hi. You may have answered this but I just want to clarify and I apologize. We're actually a hospital and we have ten provider based practices. Can you tell me how many records I could expect?

Now I think we have enough services as the hospital itself to generally meet the 200 for 45 days maximum but I'm curious about how the provider based practices are going to work.

Marie Casey: This is (Marie Casey). Are you talking about provider based prices like a hospital that's working in your inpatient facility or are you talking about outpatient Part B billers?

(Cherry Clavette-Arnold): Outpatient Part B billers. We have internal med, family practices and a cardiology practice.

Marie Casey: And all your medical records are housed with the inpatient records, your Part B service records are housed with your inpatient records or are those Part B records in each individual physician's outpatient office?

(Cherry Clavette-Arnold): They're in each office.

Marie Casey: And do you have one MPI for these services or one MPI that covers both all your inpatient stuff, your inpatient claims as well as any outpatient claims?

(Cherry Clavette-Arnold): We have an MPI for the set of internal medicine practices, an MPI for the set of family practices and two separate MPIs for the cardiology services, so a total of four for the practices.

Marie Casey: And again see this is where it gets a little bit complicated and we actually really will probably need you to work with your RAC.

What our thought is we didn't want to overwhelm one central like medical record center but it sounds to me like per MPI per outpatient center you house your medical record within that particular building or that particular location. So the RAC will need to work with you regarding your limit.

(Cherry Clavette-Arnold): Okay.

Marie Casey: Okay?

(Cherry Clavette-Arnold): Thanks.

Marie Casey: Yes.

Operator: The next question is from (Christy Sarasin) from Maryland. Your line is open.

(Christy Sarasin): Hi this is (Christy Sarasin) with (unintelligible) Group. Something that I haven't heard much about but maybe you can help me with, the RACs are obliged to turn over to the proper entity when they determine that there's a possibility of fraud or abuse.

And I get that but what would the provider expect to see in the way of communication from the RAC in the event that this has happened and what is the process from there?

Scott Wakefield: (Christy) we're having a little problem with hearing you on this and could you repeat the last part of that question. I kind of got the first part.

(Christy Sarasin): My question is, you know, the RACs are obliged to turn over to the proper entity when they determine when there's a possibility of fraud or abuse.

And I'm wondering what the provider might expect from the RAC in terms of communication in the event that occurs. And what the process would be from that point forward.

Scott Wakefield: Okay well it's a good question. First of all one thing you want to keep in mind is that the RACs are not, they're not targeting fraud or abuse. That would be the program safeguard contractors.

But in the event that there is something so egregious called to the RAC's attention, I'm trying to think of an example, maybe a whiteout on a medical record or something or a number of medical records the RAC would be required as you suggested to report that to the CMS project officer.

And no, the provider probably would not get a heads up on that because as in any situation where there's potential fraud or abuse, you know, it would probably end up in the program safeguard contractor or SEPI as they're now known.

In their shop or it may end up in law enforcement and as you can imagine we wouldn't want to give a provider a heads up.

With that said though the RAC, the RAC would still work with the provider to maybe talk to them about it to see if there's, you know, if there's a reasonable explanation. I guess it would be kind on a case by case basis.

(Christy Sarasin): Okay. And my last question is at the recent RAC Summit HDI had indicated that they were up and ready to go with electronic record requests from their providers. They were waiting on CMS for that approval. Can you tell me where you are in that process?

Ebony Brandon: That's really going to be a late to be honest (Christy). It's not that that the RACs aren't ready because trust me I think many of them would love to accept an electronic medical request but across it's not just RAC either it's across CMS we have someone on staff that works on that and she can speak more to that (Pam)?

(Pam Durban): Yes, hi, thanks this is (Pam Durban) and I am with the ERAC project here and we are hopefully eventually going to have electronic medical records, have the RAC request them from providers but that is way off in the future. Unfortunately but we are currently working on it.

(Christy Sarasin): Well you just shot that optimism.

(Pam Durban): Okay.

(Christy Sarasin): Thank you very much.

((Crosstalk))

(Pam Durban): Sorry about that, we'd like it too.

(Christy Sarasin): Well, you know, I just had to wonder with all the wonderful technology why we're still sending letters that sometimes get lost in the mail.

(Pam Durban): Information security is very important to CMS, and we take the information that is contained in the medical record. Identity theft is out there, and when you're transmitting information (PHI) over the internet, we take that very seriously and want to make sure that we have the security architecture in place to protect that when you transmit it to us

(Christy Sarasin): Well I won't hold my breath on that one then, thank you.

(Pam Durban): You're welcome.

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

Operator: Okay your final question will be from (Ria Story) from Alabama. Your line is open.

(Ria Story): Sorry we withdraw the question. Our question's been answered.

Natalie Highsmith: Okay we'll go ahead and end the call now we have reached our 3:30 out here on the East Coast. Marie, any closing remarks?

Marie Casey: Yes I just wanted to thank everyone for listening to our present today on the National RAC program. I do ask that you feel free to use that last email address to send us your questions.

I know there were many questions about medical records when they change providers. We will and we have even during the demonstration tried to actively provide information to the provider community in our frequently asked question that we post to the Web site.

So I do encourage you if you have any questions about the RAC program to go ahead and send us those questions and we'll post those and then that way we can share them with the entire provider community. And thank you Natalie, that’s all.

End of Transcript

Centers for Medicare and Medicaid Services
Clarifying Statements from the
Special Open Door Forum:
Recovery Audit Contractor (RAC) for Part A Providers
Wednesday, April 8, 2009

If a Part A Inpatient Facility has hit their maximum limit of 200 records per 45 days, the RAC may not ask for additional Part B medical records in the same 45 day period (provided the medical records for Part B services are located in the same medical record room).

If a bi-state provider has 2 different claims processing contractors they may have two different RACs audit their claims.

Please email any questions to: RAC@cms.hhs.gov