Centers for Medicare & Medicaid Services
Special Open Door Forum:
Part B Providers, Recovery Audit Contractor (RAC)
April 14, 2009
2:00 PM – 3:30 PM EST
(Conference Call Only)

CMS is hosting this Special Open Door Forum for Part B provider recovery audit contractors (RACs) on April 14, 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 92489480

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

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

An audio recording of this Special Forum will be posted to the Special ODF website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning April 22, 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_RACPtBProv.mp3

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Recovery Audit Contractors for Part B Providers
Moderator: Natalie Highsmith
April 14, 2009
2:00 pm ET

Operator: Good afternoon and welcome. My name is (Patricia) and I'll be your conference operator today. At this time, I'd like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum: Recovery Audit Contract for Part B Providers.

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 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Ms. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, (Patricia), and good day to everyone and thank you for joining us for this Special Open Door Forum for Part B Providers: Recovery Audit Contractors.

Today, CMS staff will introduce Part B providers to the new contractors and provide more information about the RAC program.

On October 6, 2009, CMS announced the awards for the four permanent RACs. These RACs will be responsible for identifying overpayment and underpayment in approximately 1/4 of the country.

For further details, you can go to www.cms.hhs.gov/rac, R-A-C. I will turn the call over to Ms. Marie Casey, who is a Deputy Director of Recovery Audit Operations. Marie.

Marie Casey: Thank you, Natalie. And thank you to all providers who have joined us for our call today. The purpose of this call is to conduct a presentation on the National RAC implementation and RAC operational processes.

We unfortunately at this time are unable to answer detailed questions about the RAC program demonstration, the appeals process or the recoupment process. These issues do not currently involve our current recovery audit contractor.

However, questions concerning these issues, or if you have questions concerning these issues, please send them to our RAC staff here at CMS. And I'm going to provide you with that email address.

The email address is rac@cms.hhs.gov and we will ensure that we forward those questions to the appropriate division here at CMS.

And without anything further, I'm going to turn it over to our actual presenters today. We have Commander Kathleen

Wallace, who will be presenting today. She is our Region D project officer.

And we also have Amy Reese who is our Region C project officer for the RAC program. And once again, thank you for joining our call today.

Kathleen Wallace: Thank you, Marie. This is Kathy Wallace, Region D project officer. I will do the first half of this presentation and then I'll turn this to Amy Reese. Welcome to RAC 101. This is the who, what, when, where, why and how of the RAC process.

As you know, improper payments have not been a new issue for CMS. We've been looking at improper payment since 2002 with the IPIA Act, which is the Improper Payment Information Act of 2002.

That Act mandated CMS and all federal agencies to measure and reduce improper payments. As a result, CMS had instituted the CERT program. And in 2003, the CERT error rate was about 9.8%.

By 2003, it had been reduced to 3.9%. And what does that mean to you? That means that the CERT was able to estimate the error rate and give an estimate of improper payments, which equates to about $10.8 billion.

So with those improper payments, you have CMS processing a number of different claims. They process a billion per year, 4.5 million claims per day.

So it’s no wonder that some of the claims get through the front end with the FIs and carriers, either through human error, or computer error or the fact that we don't edits for every single service for every claim that’s submitted, which brings us to the RAC program.

So the MMA Modernization Act, Section 306 had instituted or forced CMS to develop a demonstration program. So CMS had established the RAC program. And the mission of the RAC program is to detect and correct past improper payments so that we can prevent any further ones.

And who benefits from that? Well, providers invariably send in claims and they get processed, it will avoid any sort of delays in reimbursement.

CMS is able to lower its error rate and tax payers are assured that we are protecting the Medicare Trust Fund and that the improper payments are being returned to the Trust Fund for future Medicare beneficiaries, which includes myself.

So who gets affected from the RAC program? Anybody that sends in a claim for Medicare fee for service. We have outreach that’s currently being done in different states, there are certain timeframes.

We had yellow states, we had green states and because of the protest, which had been lifted in February, we are now providing outreach in both yellow and green states.

And those yellow states and the green states have now become one. And if you look at the RAC Web site, you'll see a number of states that are scheduled for outreach in your area.

Now since we had the demonstration program for three years from March '05 to March '08, Congress just loved that program. So they've instituted legislation for a permanent RAC program through the Tax Relief and Healthcare Act of 2006, Section 302.

Both of those statutes, I had mentioned earlier, the MMA 306, that governed demonstration program, and this last one that governs the permanent program, both of these statutes give CMS the authority to pay the RAC by on a contingency fee basis.

So now what do RACs do? Well RACs review claims on a post payment basis. Those are the claims that actually get through the front end, which I had mentioned, the MACs, the FIs, and the carriers.

So the RACs will come in on the back end and they will be processing claims looking for those improper payments. They will use Medicare NCDs and LCDs policies, Medicare policies, CMS rulings in order to look at those claims.

There are two types of reviews that will be preformed, there’s automated and then there’s complex. In the automated, it’s basically the black and white of looking at claims and making sure that there’s a NCD and LCD that support the improper payment.

So you'll have an automated review and the RACs will look at those claims. And with certainty, they will send a demand letter if there’s no NCD or LCD governing - or if there is an LCD, NCD governing those claims.

For a complex, they will process those claims without an NCD or LCD. And if they find an issue, they will send you a medical request letter. Once you get that medical request letter, you need to send the medical records to the RAC within 45 days plus 10 calendar days.

The RAC will then review that chart and they'll conduct an audit on that chart. And they have about 60 days in order to do so. They will send a letter, a demand letter - review results there, sorry, - to the provider or facility to let them know what they had found on that audit.

At that point, when you receive that review results letter, that begins your discussion period for the complex review. That means you pick up the phone and you call the contractor and you discuss the case. You have the review results letter to indicate what they found.

And if there’s any other additional information, use that discussion period to contact them, find out what it is that you need to send in to support your claim and possibly dismiss the audit.

If the claim is not resolved, they will issue a demand letter to you letting you know that the issue is not able to be resolved. And you will have to pay the claim based on offset or by check.

The collections process is the same as for carrier, FI, MAC. Carriers, FIs, and MACs issues a remittance advice. Once that demand letter is sent, there will be an AR and/or a remittance advice sent. The remittance advice will let you know that there's been a RAC adjustment.

And that code will be N432. The carrier, FI, MAC will recouped by offset unless the provider has submitted a check or initiated a valid appeal.

So what's the different between or what's different? The demand letter is issued by the RAC. The demand letter is not issued by the FI, the MAC, or the carrier. As I had mentioned, the RAC will offer the provider an opportunity to discuss the improper payment determination with the RAC.

And it's through the discussion period I had mentioned. And that discussion period is very unique to the RAC program. It's not part of any other claims processing contractor.

It's unique to the RAC. Use that discussion period, take full advantage in order to resolve the dispute. Any issues reviewed by the RAC will be approved by CMS prior to widespread review. And then the approved issues will be posted to the RAC Web site before widespread review.

What are the providers' options? I had mentioned, they can pay by check. They can allow recoupment for future payments, they can request or apply for an extended payment plan or they can appeal.

There is a Web site for appeals and there's a Web site for 935 for educational purposes. If you want these Web addresses, I can give them to you at the end of the presentation.

I will now allow Amy Reese to finish this presentation.

Amy Reese: Thank you, Kathy. Hi everyone. Again, my name's Amy Reese and I'm the project officer for the RAC in Region C. I'm going to start off by discussing some of the changes we've made to the national program. And talk about our three keys to a successful RAC program moving forward.

Those three keys to success are to minimize provider burden, to assure accuracy and to maximize transparency. To minimize provider burden, we instituted a number of changes. We have limited the RAC look-back period to three years.

In the demonstration, the RAC could review claims that were four years old. We have reduced that to three years. And we have put in place a maximum look-back date, which is October 1, 2007.

Obviously when the RACs get started reviewing claims, that look-back period will only be about 18, 19 months or so but eventually that will go forward to a full three years.

Another change that we've made is that the RACs are required to inspect imaged medical records on CD and on DVD. They are, you know, still required to accept paper records via fax or mailing them in but we've provided another avenue for providers to get those records in to the RAC.

You will need to work with your individual RAC to make sure that, you know, all your technical things are compatible as far as them reading what you send. But they are required to work with you to make sure that they can accept your CDs and DVDs.

Also we've limited the number of medical records that the RAC can request from you. And for this current fiscal year, we have instituted some limits for Part B providers. And these limits are, in general, they are based on the NPI and they are for every 45 days because you have 45 days to submit the record to the RACs.

And we have limits that are per 45 days. I'll read these to you real quick. For physicians, a solo practitioner, the RAC can request ten medical records. A partnership of two to five individuals, the RAC can request 20 medical records.

For groups of - group practices of between 6 to 15, the RACs can request 30 medical records. And for large groups of more than 16 providers, the RAC can request 50 medical records.

Again, generally these limits are done by NPI but we do realize that we can't take into account every situation and every different way that, you know, a facility or group decides to

organize themself. So we encourage you to work with your RAC to make sure that the limit is appropriate for your needs.

And also, we have for other Part B billers other than physicians, which include DME, lab services or outpatient hospitals, so that generally would be 1% of the average monthly Medicare services.

And then there's a cap of 200 of those. So if 1% of your average monthly Medicare services comes out to more than 200, your limit per 45 days would only be 200.

We also want to make sure that we're ensuring the accuracy of the claims determinations that the RACs are making. And we have required that the RACs employ a qualified staff to review your claims.

They're required to use certified coders as well as nurses or therapists to review claims. And they are all required to have a full-time physician medical director on staff.

Also, in the permanent program moving forward, CMS has instituted a new issue review process that will give - will let CMS have greater oversight of the issues that the RACs are planning to look at.

We are going to utilize a review board, which is made up of different members from different areas around CMS such as coverage staff, policy staff and appeals staff that will assist us in reviewing and looking at what exactly - what exact services or codes, et cetera, that the RACs want to look at.

We also have an independent RAC validation contractor that will help us with those new issues as well. And the RAC can only move forward with a widespread review of any particular issue if it has approval from CMS.

Also that RAC validation contractor will help us in another way by providing an accuracy rate for each of the RACs. They're going to be doing a sample of claims each month. And we will be publishing the accuracy score for each RAC annually.

Most likely that score will be published in our annual report, which will be available on our Web site. And also, a major change that we have instituted since the demonstration is that the RAC must return its contingency fee if it loses at any level of appeal.

In a demonstration, the RAC only needed to return that contingency fee if it lost at the first level, they got to keep that moving forward to the higher levels. But in the permanent program, they will return that fee if they lose at any level.

We also want to maximize the transparency of the program so the providers know what the RACs are doing and what, you know, what CMS is doing in our oversight efforts.

Those new issues that I talked about earlier, once CMS has approved a new issue for the RAC to review, those issues will be posted to the RAC's Web site.

So providers can, you know, check that Web site and see, you know, what the RAC may be reviewing. That doesn't necessarily mean that, you know, you will see a demand letter or a medical record request letter for any particular service. It just means that the RAC, you know, is looking at that type of data.

Also, we're going to be posting vulnerabilities to the Web site as well. And when we say vulnerabilities, we're talking about problems, the issues that CMS has approved that the RACs have started reviewing on a widespread basis that have shown themselves to pretty widespread problems, you know, throughout the region or throughout the country.

Also, the RAC by January 1, 2010, all the RACs will be required to have a claims status Web site. And this Web site will allow providers to log in and check the status, you know, of a medical record, can see if the RAC received it and, you know, see when it was sent and when it received.

That Web site will also allow you to customize your address and contact information of where you would like correspondence to come from the RAC.

In the meantime - since that requirement doesn't go in to effect until January 1, in the meantime if you do need to customize an address or some contact information to make sure that your medical record requests and letters are going to the correct place, please call the RAC and, you know, see what their process is for doing that.

Also, following all complex reviews, which as Kathy said earlier, were ones where the RAC has requested a medical record from you. The RACs are required to send you a detailed review results letter following those reviews.

We did get some comments in the demonstration that there wasn't enough detail. Providers were still kind of unsure why there was an improper payment and what the RACs were looking at.

So the RACs are going to, you know, be able to tell you specifically what it was in the medical record or what it was in the documentation that you sent over that wasn't complying with the rules and therefore resulted in an improper payment.

There are a few things that providers can do to get ready for any kind of potential RAC reviews. First of all, know where improper payments have been found. You can look on our RAC Web site to see the - we have links to the demonstration findings.

We have some yearly status reports as well as an entire report from the three year evaluations. That Web site again is www.cms.hhs.gov/rac, R-A-C. Also moving forward, look at your new RAC Web site, they’re going to be posting those new issues on there as well as the vulnerabilities.

Also look at what other entities have found as far as improper payments. You can look OIG reports, GAO reports, as well as CERT reports. You know, the RACs are getting their information as far as where to look for improper payments on these same

places, so, you know, take advantage of being able to look at those reports.

Also, please realize within your facility or within your group, you know, figure out if you are submitting claims with improper payments. Conduct an internal assessment and see if you're in compliance with rules.

And if necessary, implement some corrective actions so you can make sure that you're in compliance moving forward. Also and very importantly, you want to make sure that you're prepared to respond to RAC medical record requests.

I think Kathy and I both mentioned that you have 45 days plus five mail time days on either end to send in those medical records.

But if the RAC hasn't heard from you, if you haven't requested and extension to get those in or if they haven't received your medical records, they can deny your claim. So make sure that the RAC knows where they should send those medical record requests.

And like I said before, that address customization Web site will be up in January, but until then, please call the RAC. Most of them have some kind of form that they'd like you to fill out to, you know, to make sure that they have all the information necessary.

And within your office or within your facility, make sure you identify someone to respond to those record requests as well

as, you know, a backup if someone’s going to be out of the office.

Also take advantage of the RAC discussion period that Kathy just talked about earlier. This is something that’s unique to the RAC program. If you've received a review results letter and you don't agree or you think there might be, you know, some documentation that the RAC overlooked or maybe you overlooked in sending, contact the RAC.

Get that information in and make sure that, you know, you have a discussion about before that claim gets adjusted and you have to go through the appeals process.

If you can take care of, you know, or maybe some simple things like that earlier, then I think that’s better for all parties involved.

But this discussion period, this is kind of outside of the normal appeal process. So if you think that you’re still, you know, you’re not really getting where you want to be with the RAC, you have the right to appeal.

And, you know, those appeal rules for RACs are no different than the appeal rules for any other claims processing contractor. And, you know, you do have the right to use that process.

And just in closing, make sure that you learn from your past experiences. If you were involved in the demonstration, you know, hopefully you’re keeping track of what happened, you know, patterns of denied claims.

And if you, you know, are contacted from a RAC in this permanent program, you know, look for those patterns again, track what, you know, what they're looking at, what's getting denied.

You know, decide if you need to implement those corrective actions to avoid getting any other requests for medical records or demand letters for improper payments.

And that is all for our presentation from our point. I do want list our RAC Web site again, which does have a lot of good information on there. And again that's www.cms.hhs.gov/rac. And we do have a RAC email address.

I'll give you that address again if you missed it the first time. You can feel free to send any of your questions there. That is a monitored email box and we will get you an answer. That address is rac, R-A-C, @cms.hhs.gov (RAC@cms.hhs.gov). And that's all.

Natalie Highsmith: Okay. Thank you, Kathleen and Amy. Now (Patricia), we are ready to move into our open Q&A portion of the call.

Let me just remind everyone, once you get into the queue to ask a question, to restate your name, what state you are calling from, what provider, or organization you are representing today.

And also since we have quite a number of folks on the phone lines, we have a 1000 or a little over 1000 today, that if you have more than one question, that you ask your first question

and get back into the queue to ask your second question or remaining questions. (Patricia)?

Operator: Yes, at this time I'd like to remind everyone to press star then the number 1 on your telephone keypad.

And then our first question comes from the line of (Renna Lewis) from Maryland. Your line is open. Go ahead, ma'am. (Renna Lewis?). Okay, I'll go ahead and go to the next question.

Your next line - your next question comes from (Ginger Reding) from California. Your line is open.

(Ginger Reding): Yes, I'm from UCSF Medical Center. I don't know if you can answer this about the number of claims that can be requested.

We process our inpatient and outpatient all through the same medical records department. And we have about 1300 physicians at our facility. How they're going to look at that for how many requests they can make in a 45 day period?

(Terry Lew): Good afternoon, (Ginger). This is (Terry Lew). I'm with the CMS, the RAC program here. We're still refining some of the details.

But our goal is that no institution gets overwhelmed with medical record requests. And so we would have a cap of 200 for all of your services, inpatient, outpatient, physician practice combined.

(Ginger Reding): Okay.

(Terry Lew): Now again, we're having trouble pinning down exactly how that's going to work because I think as either Kathy or Amy said, there's pretty much an infinite number of ways that organizations have configured themselves.

And that makes applying the limits consistently and fairly a little challenging. And that's definitely something we're working with. But again, for your large physician practice, your (unintelligible) practice, the limits there would be 50.

You would add to that whatever the limit would be for your inpatient services, your outpatient services, whatever services you have. And so each one would have its own limit and then in the aggregate, it would be subject to that 200 record per 45 day cap.

(Ginger Reding): Okay, well that's helpful. Thank you.

Operator: Your next question comes from the line of (Toni Ambrofy) from Texas. Your line is open.

(Toni Ambrofy): That's okay, you just answered our question. Thank you.

Operator: Your next question comes from the line of (Anna Marie Carducci) from New York. Go ahead, ma'am.

(Anna Marie Carducci): Hi, good afternoon. It's actually a process question. I believe Commander Wallace said that for the complex reviews, the first step would be for us to receive a review results letter.

And if the overpayment or underpayment was still in question, the next step would be for us to receive a second letter, a demand letter. That was not the process in the demo. So I just need to clarify that.

And also I believe Amy said that we would get a detailed review letter for all complex reviews. So does that imply that we're also going to get a letter to say there are no issues with this record that we sent? That's my question?

Kathleen Wallace: All right, this is Kathy Wallace, let me respond. You will get a letter requesting the medical records. Then you'll submit the medical records to the RAC. Now remember you have that 45 days plus ten calendar days in order to get those records to the RAC.

The RAC has about 60 days to audit that chart. And they will send you a review results letter. And they'll let you know what they find in the audit so that you're aware. And when you receive that review results letter that is the beginning of your discussion in the complex review.

So take advantage of that time to call the RAC and find out what it is you need to do in order send in information to support your claim. If during that discussion period, nothing is resolved and the RAC hasn't changed their mind, then they will send a demand letter.

(Anna Marie Carducci): So it is a second letter that you send.

(Kathleen Wallace): Yes and you...

((Crosstalk))

Kathleen Wallace: Yes, and this is a very lengthy process, so you really have a large amount of time to discuss these things with the RAC.

(Anna Marie Carducci): So when does the appeal, first level appeals is 120 days from the date...

(Kathleen Wallace): From the demand letter.

(Anna Marie Carducci): Demand letter, not the review results?

(Kathleen Wallace): No, no, no, demand letter.

(Anna Marie Carducci): Okay, thank you.

(Kathleen Wallace): You're welcome.

Operator: Your next question comes from the line of (Caroline Cloud). I don't see the state. Go ahead, ma'am.

Woman: Take it off of mute. Go ahead.

(Caroline Cloud): Which one is mute?

Woman: You're on.

Operator: We can hear you.

Man: They can hear us, good. We're from the wild and wonderful West Virginia. Just a quick question about you have encouraged us to use the discussion period as opposed to waiting to go to appeal.

Is there any disincentive on the part of the vendor to not - disincentive for reversing a decision? I mean, are they penalized in any way if they reverse decisions?

Kathleen Wallace: No, it's in your favor.

Man: So I understand that. But are they - is it a mark against them if they reverse decisions?

Kathleen Wallace: Oh, no. No, no, no.

Amy Reese: Are you referring to if they decide to, you know, withdraw that claim due to something that was, you know, talked about in discussion period?

Man: Yes.

Amy Reese: No. But they, you know, it's kind of works in both of your favor to not have that claim adjusted and then go to appeal and chance that that claim may be turned - may be overturned on appeal if its, you know, something that's easily able to remedy during that discussion period.

Man: Okay.

Operator: Your next question comes from the line of (Matthew Mesibov) from New Jersey. Your line is open.

(Matthew Mesibov): Thank you, hi. This is (Matt) from (Fox Rehabilitation). If an organization has EMR, will we be able to send in our records electronically or it is by paper through the mail?

(Kathleen Wallace): Paper or CD, we're not doing electronic quite yet. It's been discussed, there is some things in motion but that may be a while, a long while.

(Amy Reese): And just to add a little bit more information, there are some large release of information vendors and larger providers that have access to the Medicare network. It's an MDCN line. It's kind of a dedicated connection to Medicare.

Those providers, you know, that's kind of a separate way to send medical record documentation, you know, through that kind of electronic port. But that's - it's not something that, you know, most providers have access to.

So we do, you know, encourage you to stick to the paper, which fax is also an option as well.

(Matthew Mesibov): Okay, thank you.

(Terry Lew): To clarify actually, right now no one is set up on the RAC end to accommodate electronic data interchange. That's not something we're equipped for and we probably won't be any time in the near future.

We can accept imaged medical records through a certain form but we're not set up for electronic data interchange right now.

(Matthew Mesibov): Okay, great. Thank you very much.

Operator: And your next question comes from the line of (Amanda Lacombe) from Louisiana. Your line is open.

(Amanda Lacombe): Yes, ma'am. My name is (Amanda Lacombe). I'm with Earl K Long Medical Center. And we were wondering, we don't appear yet on your provider outreach schedule. Do we know when that will be available for Louisiana?

Kathleen Wallace: Let me just check something here. You're considered a blue state. So in the future, I'm sure you'll receive something. They can start provider outreach in August.

(Amanda Lacombe): In August?

Kathleen Wallace: Yes, they can start in August, maybe towards the end of July.

(Amanda Lacombe): Okay and we're (Connolly) correct?

Kathleen Wallace: Absolutely.

(Amanda Lacombe): Okay. All right, thank you.

Kathleen Wallace: You're welcome.

Operator: Your next question comes from the line of (Penny Osmon) from Wisconsin. Your line is open.

(Penny Osmon): Hi, this is (Penny Osmon) from the Wisconsin Medical Society. And my question, I believe also is a process issue. Kathy had mentioned that upon receipt of the notification you had 45 days plus ten calendar days.

And Amy worded it a bit different saying it was five days on either side from mail time. Could you provide an example using actual dates so that we can kind of get a feel for if it's truly 55 days or it's five on either end?

Kathleen Wallace: Its 45 days plus ten calendar days. And we add the calendar days for those facilities that are in rural areas. And it takes a while for the postal system either to get to you or from you to the RAC.

(Penny Osmon): So that five on either end, is it five on either end from the date on the letter? Or is it truly just ten calendar days on top of 45?

Kathleen Wallace: So, you know, if it gets to you within two calendar days and that means on the back end you have another eight to ten...

(Penny Osmon): Okay, that makes sense. Thank you.

Operator: Your next question comes from the line of (Susan Lydic) from Pennsylvania. Your line is open.

(Susan Lydic): Yes, I'm a home health agency in Pennsylvania. And I tried to listen to the open door forum last week for the Part A and was unable to get on because the lines were all full.

Is the information I got today applicable to Part A also? Or is there going to be another session for Part A?

Kathleen Wallace: It's all very applicable.

(Susan Lydic): Okay. So I got enough today?

Kathleen Wallace): You bet. And I bet I did a good job, too?

(Susan Lydic): Thank you very much.

Operator: Your next question comes from the line of (Wendy Trout) from Pennsylvania. Your line is open.

(Colleen Dealy): Hi, I have a question. My name is (Colleen Dealy) from (Wellspan). And my question is basically about concordance. I'm not sure if you can answer that in this forum or not.

But say that you have two claims coming into the RAC - or to the MAC. And one is from the hospital and it lists three procedure codes that are appropriate. And then you get another claim from the physician, the provider, and they put down a nonspecific code.

So which ones do they honor? Does that stop the claim right there? Or do they honor the first one that comes into them? Or how does that work?

Kathleen Wallace: Are you talking about a duplicate claim from the hospital and from the provider?

(Colleen Dealy): Actually it's both sides, one's a physician side and one's the hospital side. And what we're hearing is that when the RACs review those together, they call it concordance.

If they don't match, we have heard that they are denying both sides not looking at it and saying well the hospital's right or the provider's right. They're just denying both outright. Is that correct?

Marie Casey: No, that it not necessarily correct.

We don't mandate what type of reviews a RAC may choose to do. That being said, the RAC may choose to look at only the inpatient stay and not look at the other per fee services associated with that.

Again, it's dependent on the recovery audit contractor that may be looking at both of those claims. They may be only looking at one of those claims.

(Colleen Dealy): Okay, thank you.

Operator: And your next question comes from the line of (Natalie Warf) from Tennessee, your line is open.

(Natalie Warf): Thank you, this is (Natalie) from HCA. Just a quick question, probably for (Terry) in reference to the medical record limit.

Do ambulatory surgical centers and like freestanding radiation oncology, are all of those considered other Part B billers and fall under that 1% limit?

(Terry Lew): That's correct.

(Natalie Warf): Okay. And what about closed facilities? Are the RACs - is it truly closed and divested, how are those going to be handled? Will they still be audited by the RACs?

Marie Casey: This is Commander Marie Casey and we are actually in the process of looking at that very issue. And we are going to be posting a Q&A to the Web site shortly and hopefully it will answer or address that question.

(Natalie Warf): Great, thank you.

Operator: Your next question comes from the line of (Jeanne On) from California. Your line is open.

(Jeanne On): Hi, this is (Jeanne). My question is, we are a large organization and I wanted to know if we can request duplicate notification center administration?

Kathleen Wallace: You want to two letters, is that what you're saying?

(Jeanne On): Yes, is that possible?

Kathleen Wallace: Two of which letters? All of them?

(Jeanne On): Yes.

Kathleen Wallace: What region are you in?

(Jeanne On): C, California.

Kathleen Wallace: Is (Connolly) on the line?

((Crosstalk))

(Lane Edenburn): HDI is on the line.

Kathleen Wallace: (Lane) can you address how you might handle a situation like that? Would that be something you would be able to do?

(Lane Edenburn): We might take it under advisement. I think my first initial reaction would be that would be probably difficult to do.

We are in intending to use the billing provider address, for instance, as the carrier would do or the MAC would do initially, unless we get a different request. But duplicates, we've really not had that question before.

But if the caller would like to send an email with that question to racinfo@emailHDI.com, we will take a look at it internally and get back to the caller.

(Jeanne On): Can you repeat that email address again please?

(Lane Edenburn): Yes, it’s rac, R-A-C, info, I-N-F-O, @emailHDI.com .

(Jeanne On): Thank you.

(Lane Edenburn): Thank you.

Operator: And your next question comes from the line of (Loretta Herfel) from Wisconsin, your line is open.

(Loretta Herfel): Thank you. Do you have the individual Web sites for the RACs? I know that like CGI has given a new Web site where you can check for various items. Do the other RACs have Web sites?

Amy Reese: Currently if you look on the RAC Web site at CMS, the RACs that do have operational Web sites will be listed on that main - on our main Web site.

A few of the RACs Web sites currently aren't operational but when they are, their addresses will be listed on our main Web site.

(Loretta Herfel): Thank you.

Operator: And your next question comes from the line of (Debbie Tocco) of Indiana - I'm sorry, Indiana. Your line is open.

(Debbie Tocco): Hi, this is (Debbie Tocco) from St. Francis in Indiana. And I'm wondering will PRG-Schultz be reviewing all records or will they be specifically reviewing home health and DME for Indiana?

Kathleen Wallace: I know for region D, PRG-Schultz will be doing home health. And in J2, which is the Washington, Oregon, Idaho and Alaska

area, they will be processing mainly all claims. But for region C - standby...

((Crosstalk))

(Scott Wakefield): Yes, I'm sorry, it is on the Web site - it's on the CMS RAC Web site. PRG's scope and their purview.

Ebony Brandon: Did that answer your question?

(Debbie Tocco): Yes, I'll check again.

Operator: Are we ready to go ahead?

Natalie Highsmith: Yes, please.

Operator: Okay, thank you, one moment. And your next question comes from the line of (Yoram Tanay) from D.C. Your line is open.

(Yoram Tanay): We're a nursing home in D.C. and my question relates to the level of requests where you mentioned that it can be 1% of the average monthly or 200 for 45 days.

How would it be counted in a nursing home whereby we put on each bill multiple lines for Part B? Is each line counted as one or will each bill be counted as one?

(Terry Lew): Each line will be counted as one Part B service. You would also be subject to the 10% of your claims for your inpatient care. And then combined, those two would be subject to the overall cap of 200.

(Yoram Tanay): Now you're referring to last week's presentation, which I couldn't get on. What was that 10%?

(Terry Lew): For inpatient facilities, the limit is 10% of average claims. For facilities such as yours where you have both the inpatient and the outpatient services, you would be subject to the independent limits for each business line.

And then the combined limit for your facility, in case you were exceeding 200 on either side, your overall limit would still be 200.

(Yoram Tanay): Overall would be 200 and Part B for each line will be counted as one?

(Terry Lew): Correct. You would be subject to 1% on the Part B side, 1% of your average monthly services with a limit of 200 record requests for your outpatient.

You would be subject to a limit of 10% of your average discharges, your average claims on your inpatient side, again with the limit of 200.

But with an overall limit for your facility of 200. So you could have 50 inpatient, 40 outpatient or 200 and zero if those were your percentage limits.

(Yoram Tanay): Okay, thank you very much.

Operator: Your next question comes from the line of (Charlene Nutter) from Ohio. Your line is open.

(Charlene Nutter): Thank you. This is Charlene Nutter and I'm calling from Columbus, Ohio of The Quality Management Consulting Group.

I had heard a speaker from a RAC demo state who indicated that when a physician is involved in a case that the hospital's money was taken back, example being a medically unnecessary inpatient stay, that the physician's money would also be taken back. Is that true?

Amy Reese: Again, that's kind of - that's going to be dependent on what that particular RAC chooses to review. If they choose to review that physician claim associated with a hospital stay, then they, you know - then that could be a possibility.

(Charlene Nutter): Thank you.

Marie Casey: Amy, I just wanted to make a point of clarification on the call. If a RAC would choose to look at that Part B service that was associated with that inpatient hospital stay, we have cautioned the RAC to be very careful. That they wouldn't just make an automatic denial of that claim, that, you know, they would need to make a determination about the level of decision making, the level at the physical exam was done.

And it would not necessarily be an automatic denial just because the inpatient's stay was denied. So again, Amy's answer is correct, that either the RAC may choose to look at that Part B service.

It's not guaranteed and even if they would look at that Part B service, they, you know, would still have to make a decision as to the level of decision making that was involved and it wouldn't just be an automatic flat denial.

We wouldn't say that Part B, even if it was not reasonable or necessary, it would probably be just down-coded.

(Charlene Nutter): Okay, thanks.

Operator: Your next question comes from the line of (Pam Robertson) from Missouri. Your line is open.

(Pam Robertson): Yes, I failed to capture the discussion period (unintelligible).

Kathleen Wallace: This is Kathy Wallace. The discussion period, you're talking about for complex?

(Pam Robertson): Yes, yes.

Kathleen Wallace: That begins with the review results letter that you receive from the RAC.

(Pam Robertson): Yes and how long is that discussion period?

Kathleen Wallace: Oh, that could go - that could even go beyond receiving a demand letter.

(Pam Robertson): Okay. Thank you.

Operator: And your next question comes from the line of (Madhu Mallela) from Colorado. Your line is open. (Madhu Mallela) your line is open.

(Madhu Mallela): My question has been answered already. Thank you.

Operator: And your next question comes from the line of (Kim Martym) from Florida. Your line is open.

(Kim Martym): Hi. Yes we have a question regarding the automated . Was there a limit to those per month?

Amy Reese: No there's no limit for automated reviews because the RAC does not need to request any documentation from them. The automated reviews are things that the RAC just looks at the claims data. So there is no limit.

(Kim Martym): So they can take back as much as they want on those per month without requesting records?

Amy Reese: Correct.

(Kim Martym): Okay thank you.

Operator: Your next question comes from the line of (Lori Brocato) of Georgia. Your line is open.

(Lori Brocato): Yes thank you. I had a question regarding the remittance remark code that's going to be used for the RAC recoupment. I wanted to find out if that's going to be available at the claim level or at the line item level?

Marie Casey: We'll get back to you on that question. If you could send that question into the rac@cms.hhs.gov email address, that would be great. And we'll get an answer out to the entire provider community. Thank you.

(Lori Brocato): Thank you.

Operator: And your next question comes from the line of (Roxanne Harris) from Michigan. Your line is open.

(Roxanne Harris): Hi. I'm calling from Henry Ford Health System and I just want to know if the providers have the option to cancel or adjust the claims prior to day 41 when the interest begins to accumulate?

Amy Reese: I'm sorry, what do you mean by cancel the claim?

(Roxanne Harris): Well, you know, when you're actually in the discussion period, you know, the interest doesn't start accumulating until after the 30th day.

And if we actually agree with the RAC's determination and say yes this should not have been billed instead of waiting until the interest starts to accumulate, we were told by our RAC we need to submit a paper check which would be sort of a nightmare.

But can we actually return the funds through the normal claims adjustment process?

Kathleen Wallace: You know that's a question that pertains to the 935 recruitment process.

(Roxanne Harris): Yes.

Kathleen Wallace: So we had made announcement at the beginning of the presentation that we weren't going to address 935 questions. But please feel free to send in that question to our RAC email address. And we will send it to 935 and we'll get you a correct answer.

(Roxanne Harris): Okay thank you.

Kathleen Wallace: You're welcome.

Operator: And your next question comes from the line of (Kelly Cooney) of Washington. Your line is open.

(Kelly Cooney): My question's been answered.

Operator: Thank you and your next question comes from the line of (Shirley Falls) from Texas. Your line is open.

(Shirley Falls): Hi. I want to go back and address the NPI limits for a second. We're a large physician practice and we have seven group NPI numbers, but about 450 NPI numbers for individual providers. Will the limit be on the group NPI or the individual physician NPI?

(Terry Lew): Group NPI.

(Shirley Falls): The group NPI. Okay great, thank you.

Operator: And your next question comes from the line of (Pam Reimann) of Tennessee. Your line is open.

(Tracey McKinney): Hi my name is (Tracey McKinney). I wanted to verify whether or not if a claim is reviewed by the RAC department if it can also be reviewed by other auditing entities?

(Terry Lew): Yes and no. RAC review does not preclude future review by program safeguard contractors or program integrity contractor, Offices of Inspector General.

Generally speaking, I would say that once the claim has been reviewed by a RAC it probably will not be going back to the claims processor as far as their review processes.

But any of the potential fraud, waste and abuse entities can go back and look at things that have been reviewed by the RAC.

(Tracey McKinney): Okay, thank you.

Operator: And your next question comes from the line of (Laura Robinson) of Virginia. Your line is open.

(Laura Robinson): Hi, can you hear me?

Natalie Highsmith: Yes we can.

(Laura Robinson): Hi this is (Laura Robinson) Pulmonary Associates of Richmond calling from Richmond, Virginia. What is the limit of the extrapolation? You said there's 1% percent monthly?

(Terry Lew): There's no limit on extrapolation per se. The RACs are allowed to do extrapolation with CMS permission, although they do need to follow all of the requirements that are laid out in the CMS program integrity manual for extrapolation.

They have to have their processes reviewed by a statistician. They have to have a specifically valid sample of - it's a fairly complicated and rigorous process that's designed to protect both parties.

(Laura Robinson): Okay, how far back can they go on that?

(Terry Lew): Ultimately they'll be allowed to go back the same three years as they would be for individual claim review. Although at this point as far as the RACs are concerned, Medicare didn't exist prior to October 2007.

(Laura Robinson): Okay. And my next question is - I had one more. What are the incentives for the RAC companies to find the underpayments?

Amy Reese: The RACs have the same contingency fee for finding underpayments as they do for overpayments.

(Laura Robinson): Okay. All right, thank you.

Operator: Your next question comes from the line of (Gretchen Thompson) of Wisconsin. Your line is open.

(Gretchen Thompson): Yes I have a question in regards to, you know, when the remittance advice as far as the adjustment with the money

that has to go back. How long do you have before if you're going to submit a check to pay that off or if it comes off the remittance?

I mean, so we don't submit a check and you take it off the remittance advice. And then all of a sudden we have more money - you've taken more money - we've given you money plus you've taken money.

Is there a time frame on that? Do you understand what I'm asking?

Kathleen Wallace: Well, you know, it's not the RACs that's collecting the money. It's the RACs - I mean it's the MACs, the FIs and the carriers.

(Gretchen Thompson): Right. But my question is if, say for example, we know that we have to pay $5000, okay? So if we are going to send you a check to pay that off, and all of a sudden now it doesn't get there in time, and it comes off the remittance advice, how is that going to work?

It happens now with other things and it just makes it a lot more - I'm just trying to understand is there a timeframe so that we agree we have to send you the check by this certain date or then it's going to be taken off the remittance advice?

(Terry Lew): The remittance advice is essentially an informational document. You're issued that to say that the claim is been reprocessed and the new price is X compared to Y.

Gretchen Thompson): Okay.

(Terry Lew): That’s when of the 935 process starts. The offset doesn't happen instantly.

Gretchen Thompson): Okay, but is there like a timeline?

(Terry Lew): On day 41...

Gretchen Thompson): Forty-one

(Scott Wakefield): ...if a check hasn't been received - I don't want to delve too far into this as it’s a 935 process, in part because we’re not experts at it here. But generally speaking, you'll have those 41 days to submit a check before the offset will occur.

The process is very much the same as what you’re used to with the carriers, and FIs and MACs. The recovery process is exactly the same except you'll be receiving the overpayment demand letter from the RAC.

So whatever is currently in place and whatever you've experienced is what you'll be experiencing going forward.

(Gretchen Thompson): Okay. All right, thank you.

(Scott Wakefield): Sure.

Operator: Your next question comes from the line of (Mary Smith) from New Jersey. Your line is open.

(Mary Smith): Yes I'm (Mary) from Pulmonary and Sleep Position of New Jersey. And you made mention of a specific grouping maybe that their looking at. Where would I find that?

Amy Reese: Can you clarify your question.

(Mary Smith): The RACs maybe they're looking for, I don't know, specific codes, specific diagnosis. I'm not sure. Somewhere early you mentioned that there was certain things that were found in the demonstration that they're looking at or reviewing?

Amy Reese: Right, all the RAC findings from the demonstration, those are in a number of reports that are listed on our CMS RAC Web site.

The RACs currently aren't reviewing anything because CMS has not given them approval. But going forward, once we do give the approval, it's usually based on, you know, a specific service, whether it's a, you know, a DRG code or CPT specific code. And those will be listed on the individual RACs Web site.

(Mary Smith): Okay, so then in other words, there isn't any list right now but if I just keep watching for updates something may post.

Amy Reese: Correct.

(Mary Smith): All right, okay, thank you.

Operator: And your next question comes from the line of (Wanda Ziemba) from California. Your line is open.

(Wanda Ziemba): Yes, hi. Thank you for taking my call. My name is (Wanda Ziemba) and I'm calling from the University of California Medical Center. I have kind of a two part question about interest on reported overpayments.

The interest that begins to accumulate after 30 days, is this from the date that we received the results and therefore are we accumulating interest while we're engaging in discussion?

Or is it from the date of the demand letter? And the second part is that we have at certain seminars been given the advice that maybe we should, in order to avoid the interest, allow the offset and then institute an appeal.

But, you know, being interested in efficient law that doesn't really promote efficiency in the system. Could you comment on those two questions please?

Kathleen Wallace: (Wanda), this is (Kathy) and thank you for your question. The interest accrues from the demand letter.

(Wanda Ziemba): The demand letter?

Kathleen Wallace: That begins the 935 recoupment process.

(Wanda Ziemba): Right. But then of course you also indicated that sometimes the discussion period could extend past...

Kathleen Wallace: That's the discussion period. It's still not going to stop what happens after the demand letter is sent. All the same other rules apply.

(Wanda Ziemba): Okay.

Kathleen Wallace: Appeals, 935, so forth.

(Wanda Ziemba): And the whether or not we should take the recommendation of just allowing an offset and then launching an appeal?

Kathleen Wallace: You know I really can't tell you what to do or - You know, we provide options in these presentations. It's entirely up - it's your call. It's up to you what you do.

We just don't want frivolous appeals on something that's gravely obvious that should not have been appealed. But, you know, that still your right and you can appeal whenever you want to.

(Wanda Ziemba): Okay great well we certainly wouldn't want to do a frivolous appeal. Thank you very much.

Kathleen Wallace: You're welcome.

Operator: And your next question comes from the line of (Elaine) - your last name is difficult - from New Jersey. Go ahead your line is open. (Elaine)? .

(Elaine Capotosti): Yes thank you. In regard to the submission of the DVD and CD to the RAC, I was at the RAC Summit in Washington and it was told to us there that Medicare had not set the requirements for that yet. And the RAC said that they were not prepared to take CDs and DVDs at this time.

Amy Reese: Currently we don't. We've spoken to the RACs since then and CMS does not have any additional requirements as far as their accepting CDs and DVDs. But they, at this time, should be prepared to work with you on the submission requirements for your particular RAC.

(Elaine Capotosti): But I got the impression for Medicare was talking about specs.

Amy Reese: No, not at this time.

(Elaine Capotosti): Okay, thank you very much.

Operator: And your next question comes from the line of (Cathy Fain) of Alabama. Your line is open.

(Cathy Fain): Yes, thank you. On the automated reviews will there be a review results letter and a discussion period for that type of review?

Kathleen Wallace: No. There won't be a review results letter, there'll be a demand letter. And when you get that demand letter, that will begin your discussion period with the RAC.

(Cathy Fain): All right, thank you.

Kathleen Wallace: You’re welcome.

Operator: And your next question comes from the line of (KiKi Munoz) of Florida. Your line is open.

(KiKi Munoz): Hi my name is (KiKi) from American Ambulance Service in South Florida. We're an ambulance supplier and we were affected by the demonstration last year.

And I went to a series of reviews, and appeals and ALJ hearings. And I'm still going through ALJ hearings today.

One of the things that our experience has been is that we bill Part B. But there's times when we have to bill the Part A provider because we do provide round trips in our facility transfers and on discharges from hospitals to nursing homes or rehab hospitals.

And one of the biggest issues at the RAC level when we try to deal with them was that the hospitals were issuing the wrong discharge dates.

They were putting the next day on their discharge and that's how they would file it with Part A, even though we did the actual discharge the day before.

And they were still requesting all of our medical records. What do you suggest that we do on a go forward basis so I don't have to go all the way to the ALJ level?

Kathleen Wallace: Well that's a pretty interesting question.

(KiKi Munoz): And I could probably speak for all ambulance companies.

Kathleen Wallace: I can't address whether or not the hospital has provided the correct discharge date and how that interacts with you per se. I don't even know how to answer that question.

(KiKi Munoz): Well we, over and over again, thank God that the majority of our ALJ level hearings resulted in a favorable decisions because we were able to prove, you know, the decision making process. But it's very time consuming, it's very lengthy.

It's now we're into 2009. And I actually have a hearing on the 16th for stuff from 2005 because they don't - the RAC , they didn't understand the process. And the RAC that was involved with was (Health Data) Insights.

And when they closed down or they stopped the demonstration we couldn't contact anybody.

So and nobody understood what was going on because there is times where we do have to bill the Part A provider because it's part of their prospective payment system or consolidated billing.

But, you know , what do we do? I mean how can we inform our RAC agency to understand where we're coming from because we see it all the time? We were able to prove that the hospitals were providing the wrong discharge dates.

Kathleen Wallace: All right, you know you can, you can also use our RAC email to send that question. The RACs are also on the phone and they've heard your frustrations.

(KiKi Munoz): Yes, it is frustrating.

Kathleen Wallace: You're right, I hear you.

(KiKi Munoz): It's very frustrating.

Kathleen Wallace: If you have a questions, please feel free to send that into the direct email address.

(KiKi Munoz): Okay. All right. Thank you.

Kathleen Wallace: And I hear you.

(KiKi Munoz): You know, I know all the judges in downtown Miami.

Kathleen Wallace: Okay.

Operator: And your next question comes from the line of (Candice Kronover) of South Dakota. Your line is open.

(Candice Crownover): We've a provider based rural health clinic and the majority of our claims are paid on a per diem basis. So are we correct in thinking that those would not be reviewed? It would only be our fee-for-service?

Kathleen Wallace: Fee-for-service.

(Candice Crownover): Thank you.

Kathleen Wallace: You're welcome.

Operator: And your next question comes from the line of (Drew Hamilton) from South Carolina. Your line is open.

(Elaine): Yes this is actually (Elaine) from Florence, South Carolina. I have a question about the medical record.

When you're looking at the physician's bill and you're requesting the medical record, if it's a hospital or an ER physician, are you actually requesting the entire inpatient medical record? Or just the applicable medical records for the service that was billed?

Amy Reese: Just the applicable documentation for the service that was billed.

Operator: Okay, I think that - is she done?

(Elaine): Yes, thank you.

Operator: You're welcome. One moment. And your next question comes from the line (Donna Rana) of Maine - or Massachusetts. I apologize. Your line is open.

(Donna Rana): Can you hear me?

Natalie Highsmith: Yes we can.

(Donna Rana): Okay my question actually goes back to the discussion period and who gets notified about stopping the recoupment? And what is the timeline? I believe it was 30 days to notify. Is the RAC that we notify to stop the recoupment before the interest starts accruing?

Amy Reese: If you're already in the discussion period then you would want to contact your RAC immediately to try to stop that before the claim is adjusted.

(Donna Rana): Okay. Is that a written format, is it a verbal format? How is that tracked?

Amy Reese: You know, you want to get in touch as soon as possible so probably the phone would be your best bet.

(Donna Rana): Okay. So once that's start recoupment is issued, if you go into the discussion with the RAC and it's unfavorable you get an unfavorable decision, the interest then starts accruing from that point forward?

Marie Casey: The discussion period doesn't preclude recoupment. I just want to clarify that real quick.

(Donna Rana): Okay.

Amy Reese: And that interest start accruing with the date of that demand letter.

(Donna Rana): Which the demand letter comes after the 15 day discussion, is that correct?

Amy Reese: It's not necessarily, you know, a 15 day discussion period. But the demand letter, you know, will come, you know, sometime after that review results letter.

(Donna Rana): So there isn't a timeline about how long you can do the discussion period?

Amy Reese: Not specifically. However, you know, you'll get your review results letter. That will start your discussion period.

Then once you get that demand letter you know that recruitment will happen on the 41st day following that letter. So that should help you with your timeframes.

Marie Casey: Just so all in the audience are aware the purpose of this discussion period, and the reason why this is a process that's unique to the RAC Program, is one, we have a little bit of timeframe between when the RAC makes a determination, sends you that medical review results letter, and actually the files get forwarded over to the MAC for the demand letter to be sent, and actual recoupment starts occurring.

And it's in that period of time that we highly recommend that you contact the RAC to maybe even stop that file from reaching that MAC, or that FI or carrier. And that would actually be the easiest and best process for all of us.

But even if it's a little bit later in the process and the demand has to actually still be sent, and you manage to get a hold of the nurse reviewer, or whoever reviews your claim, you may still have time and have that window of opportunity to be able to actually stop the recoupment's from occurring.

So we do encourage you to use that process. However, we don't want you - if you, you know, try to reach the RAC, and

you’re having difficulty, and you’re nearing the timeframe in which monies are either going to be taken away from you or you're, you know, running into your appeals timeframe, we do recommend that, you know, if you have any doubt whether the RAC is going to overturn their decisions during that discussion period, that you do, you know, apply for that appeal. \

And you do, if you don't want interest to accrue, that you pay by check within that 30-day timeframe. So I just, kind of, wanted to make that clear to all.

(Donna Rana): Okay, can I just ask one more question, kind of, on the back of that?

Amy Reese: Sure.

(Donna Rana): Once that interest starts accruing, if you choose to go to appeal, does that interest accrue towards the continued levels?

Amy Reese: Yes it does.

(Donna Rana): And it accrues at 10% to 12%, is that correct?

Amy Reese: I believe its 11.0 (unintelligible). But it does change quarterly.

(Donna Rana):: I'm sorry, I didn't hear you.

Amy Reese: Its 11% right now, but it changes quarterly.

(Donna Rana): Okay, so if this takes three, four, six months it’s 11% interest that’s accruing continually on this claim?

Amy Reese: Correct.

(Donna Rana):: So ultimately at the end there could be a chunk of money taken already, correct?

Amy Reese: Correct.

Natalie Highsmith: Okay, ma'am, we must move on to the next question.

(Donna Rana): Okay.

Operator: And your next question comes from the line of (Wanda Cooper), from Texas. Your line is open.

(Wanda Cooper): Yes, we're from the Dallas/Fort Worth area. Can you tell us when (Connolly) will be doing an outreach? Or when we can expect any RAC letters coming?

Amy Reese: Hi, (Wanda), this is Amy. (Connolly) and the agency staff will be in Texas, May, I think, 13 thru 15. But that is all being facilitated by the Texas Hospital Association. So if you're a hospital provider you may want to get in contact with them.

(Wanda Cooper): We're a physician group, so how would - are they going to have a specific outreach to us? Or just for the hospital associations?

Amy Reese: We're currently working with the Texas Medical Association for that. So I would, you know, contact them and be on the look-out, you know, at their Web site. But currently nothing scheduled.

(Wanda Cooper): And does (Connolly) have a Web site that I can go to?

Amy Reese: (Connolly) does. No, actually their Web site, their RAC Web site isn't operational yet. But I was referring to that Texas Medical Association Web site, if and when something is set up.

(Wanda Cooper): Okay, thank you.

Operator: And your next question comes from the line of (David Costello), from Michigan. Your line is open.

(David Costello): Thank you, this is (Dave Costello), from Beaumont Hospital. Can you just give some clarification related to the timeframe between the results letter and the demand letter related to that discussion period?

What is the timeframe between the received of results letter and the sending out a receipt of the demand letter?

Marie Casey: It actually depends on the claims processor involved and how quickly the RACs can get those files over to the claims processing contractor. So to answer your question across the country there is no set timeframe.

(David Costello): Okay. And then you sort of answered a question of about when Texas was going to start seeing some of the things.

How about the other regions across the country? Is there a timetable or a way that we can look up that information as far as when we can start seeing some of this RAC request?

Amy Reese: Hi, we do have a schedule of all of our outreach on our CMS RAC Web site.

(David Costello): Thank you.

Operator: And your next question comes from the line of (Zina Spain), of Arkansas. Your line is open.

(Zina Spain): I'm sorry, my question was answered.

Operator: Thank you, your next question comes from the line of (Caroline Cloud), of West Virginia. Your line is open.

(Caroline Cloud): Hello, we're just - I'm trying to fill in a question for our - that was asked and they had to leave. So we're looking at the expected - what is the minimal accuracy or what kind of protocol will the RAC be held to to make sure they're treating everybody, I guess, equally?

((Crosstalk))

(Caroline Cloud): What's the universal process for them? And what is their expected denial or accuracy rate for their (unintelligible)?

Marie Casey: I'm a little confused. This is Marie Casey. Are you talking about what standards or review we will hold them to in terms of, you know, which policies they're to use?

Are you looking for a description of what we're looking for in terms of their accuracy score is that are given to us by the RAC validation contractor? I'm not sure what you...

(Caroline Cloud): Validation contractor, the latter part.

Marie Casey: CMS has not yet set a baseline. This is our first year. We'll probably use this as a year and then set our goals for our different RACs.

So no, to answer your question, we have not set, if you want to call them set performance metrics yet. We'll probably use this as our base year and then set them next year.

(Caroline Cloud): Thank you.

Operator: And your next question comes from the line of (Mary Jamo), of Maine. Your line is open.

(Mary Jamo): Thank you, I'm calling from the Maine Veterans Home. I'm just back where you were talking about the automated claim review. And you had some letters that I didn't quite hear. LCD or MTD?

Kathleen Wallace: Hi, (Mary). This is (Kathy). The NCDs and the LCDs.

(Mary Jamo): Can you tell me what those...

(Kathy Wallace): National determinations and local.

(Mary Jamo): Local. Okay, thank you very much.

Operator: And your next question comes from the line of (John Baker), of California, your line is open.

(John Baker): This is (John Baker), CBR Technologies. Do you have an idea when the physician groups will be audited by the RAC? Is it all going to happen across the board at the same time? Or will they start with acute care facilities and move across some spectrum?

Kathleen Wallace: Thanks for your question (John). No they can start any time and all claims under fee-for-service are subject to RAC review.

(John Baker): Thank you.

Operator: Your next question comes from the line of (Edith Sunderland), of Maryland. Your line is open. (Edith Sunderland) from Maryland, your line is open.

(Edith Sunderland): Hi this is (Edith), from University Physicians. My question has to do with - I'm on the physician's side. So will our audits be included in when you request hospital records? Or will we get a separate request for the physician records?

Amy Reese: It'll be a separate request for a physician record.

(Edith Sunderland): Thank you.

Operator: And your next question comes from the line of (Ethel Taylor), of Indiana. Your line is open.

(Ethel Taylor): When can we expect to hear from CGI for introduction and establishing contact information with them?

(Scott Wakefield): I'm sorry where are you from please? What association?

(Ethel Taylor): Indiana.

(Scott Wakefield): We are working right now on trying to get an outreach event coordinated. CMS will be hosting that event which is a little different approach. And we will let you know. I would continue to check on the CMS RAC Web site for posts on that event.

(Ethel Taylor): All right. Thank you.

(Scott Wakefield): You're welcome.

Operator: And your next question comes from the line of (Heather Sutton), of Illinois. Your line is open.

(Heather Sutton): Hi, thank you. My name is (Heather Sutton) and I'm with Walgreens in Illinois. I have, kind of, a general question to see if we can - kind of, once everything together. I think that for the most part the RAC is identifying claims that were under or overpaid.

But what about claims that we might have identified either way, and then the process that goes with that timely filing, you know, off of the EOB or off of a review letter from the RAC?

And if I could give, maybe, an example, if you have a patient that we submitted for enteral or supplies that maybe the claim wasn't converted correctly or entered incorrectly on the Medicare side.

Would this, kind of, fall into the automated appeal? Would we call it Medicare or would we call it the RAC? And then along the lines, maybe, Medicare hadn't got their system updated and the patient didn't even have Medicare and then the RACs found that later, what's the, kind of, the process for all of that?

And who would we call first? Would we see something come automatically from Medicare, maybe they would keep the whole payment based on the RACs findings?

And then if we did have to resubmitI know you said we weren't really going to discuss the recoupment, but know if anything needed to be sent back would we refund, you know, Medicare if we're going to send a check refund Medicare? Would anything go to the RAC?

Amy Reese: If you've identified on your own some improper payments or have questions about improper payments, your best bet would be to contact your claims processing contractor.

They can give you instructions on how to, you know, make the payment correctly and what you need to do from that end. You wouldn't be contacting the RAC directly for that.

(Heather Sutton): I'm sorry.

Amy Reese: You wouldn't be contacting the RAC directly for those types of things.

Natalie Highsmith: Okay, next question please.

Operator: And your next question comes from the line of (Loretta Herfel) of Wisconsin. Your line is open.

(Loretta Herfel): I have a question in regards to medical record request, also. I'm sorry for another question.

But when you talk about 1% of the average monthly Medicare services, my question is, if you have like an outpatient procedure and it takes like three (PTT) codes to, you know, to code that one procedure, is the procedure, like that one day episode of care, considered one service? Or is the service based on the various codes?

(Terry Lew): It's on the individual code.

(Loretta Herfel): Thank you.

Operator: And your next question comes from the line of (Connie Mize), of Texas. Your line is open. (Connie Mize), from Texas, your line is open.

(Connie Mize): This is (Connie) and I'm from Dallas, Texas. And we have a multi-specialty organization. And we have many satellite clinics.

And our billing and our correspondence address is off site. Where will these letters be sent? Will they be sent to the provider's address? Or will they be sent to our billing and correspondence address?

Amy Reese: Currently, probably the default would be correspondence will be sent to your billing address. If you want something different you'll need to contact your RAC to specify...

(Connie Mize): That’s fine. Thank you very much.

Operator: And your next question comes from the line of (Ann Marie Gaitan), of Florida. Your line is open.

(Ann Marie Gaitan): Hi, I have two questions. My first one is regarding the outreach programs here in Florida. According to the schedule that you have online, there’s only one for physicians and it’s being sponsored by the Florida Medical Associations and Orange County Medical Associations.

But my review of their Web site shows that you must be a member to attend this outreach. Is there another one that’s going to be available?

Amy Reese: Currently we don't have any other on-site presentations scheduled for Florida.

(Ann Marie Gaitan): Are you going to make one available for those who are not members of these two specific organizations?

Amy Reese: We’re working on getting some presentations posted to our CMS Web site. As well as, I'm not sure if Florida will make their presentation available for non-members afterwards.

If you want to send an email to the individual or to the specific RAC Web site we can - the CMS RAC Web site, we can try to help you out.

(Ann Marie Gaitan): Okay, thank you. And then my second question goes back to Kathy's presentation.

You know, when you were going through the what's new part, one of the things that you mentioned was that - what I understood was that disputes would be posted on the RAC Web site. Can you explain what you meant by that?

Kathleen Wallace: No.

(Ann Marie Gaitan): You don't know what I'm talking about?

Kathleen Wallace: No, I don't. You'll have to rephrase it or - I have no idea what you're talking about.

(Ann Marie Gaitan): I didn't really understand. You were saying different things that were going to change, you know, to the discussion period, the demand letter. And then you said that something was going to be posted on the RAC Web site. And I thought that...

Kathleen Wallace: New issues. So once the RAC has performed a data analysis and they've identified certain vulnerabilities, they will submit those vulnerabilities to CMS.

And CMS will research those vulnerabilities to determine and make sure that they really truly are vulnerabilities. And those will

be approved by CMS. That’s where the transparency comes into play.

And those issues will be posted to the RAC Web site. So that everybody knows what issues they'll be looking at. We can get this from what had occurred in the general.

(Ann Marie Gaitan): Okay. Thank you.

Kathleen Wallace: You’re welcome.

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

Operator: Okay, one moment. And your last question comes from (Susan Lydic), of Pennsylvania. Your line is open.

(Susan Lydic): Yes, I'm with a home health agency. And you talked about the 1% and the 200 limit for the physicians and the different things. Is there a percentage or a number limit for home health?

(Terry Lew): Home health would be the 1%.

(Susan Lydic): One percent. Thanks very much.

Natalie Highsmith: Okay we have reached our 3:30 hour here on the east coast. Did you have any closing remarks to make?

Marie Casey: Yes, I just wanted to thank all the providers for attending this call. Please look on the CMS Web site for outreach sessions that we are scheduling across the country.

And we look forward in working with all of you as we implement the RAC Program on a national basis. Thank you for your time today.

Natalie Highsmith: Okay, (Patricia), how many did we have on the phone lines today?

Operator: There was 1000.

Natalie Highsmith: Okay, thank you everyone and please remember the RAC email address for any other questions is rac@cms.hhs.gov. Thank you.

Operator: This does conclude today's conference you may now disconnect.

END