Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Fee-For-Service Recovery Auditor Prepayment Review Demonstration
Thursday, August 9, 2012
2:00PM – 4:00PM ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss the recently approved Recovery Auditor Prepayment Review Demonstration that will begin August 27, 2012.

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

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

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

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

Discussion materials for this Special ODF will be available to download at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Demonstrations.html. Discussion materials will be available on August 8, 2012.

We look forward to your participation and comments.

Special Open Door Forum Participation Instructions:
Dial: 1-866-501-5502
Reference Conference ID#:16834984

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

An audio recording and transcript of this Special Open Door Forum will be posted to the Special Open Door Forum website: http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around August 16, 2012 and will be available for 30 days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) please visit our website at http://www.cms.gov/opendoorforums .

Thank you for your interest in CMS Open Door Forums.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/080912PrePayReviewSODFID16834984.mp3

**Centers for Medicare & Medicaid Service**

**Moderator: Connie Leonard**
**August 9, 2012**
**2:00 p.m. ET**

Operator: Good afternoon. My name is (Ryan) and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Medicare Recovery Audit Prepayment Demonstration, a Special Open Forum. All lines have been placed on mute in order to prevent any background noise.

After the speaker's remarks, there will be a question and answer session. If you would like to ask a question at this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

I would now like to turn the call over to Connie Leonard. You may begin.

Connie Leonard: Thank you, (Ryan). Hello, everyone. My name is Connie Leonard. I am the Director of the Division of Recovery Audit Operations at CMS. And today we are discussing the Recovery Auditor prepayment review demonstration.

Late yesterday, we did post some slides to the demonstration web page. I understand in the announcement, the web address (inaudible). I'm just going to tell you if you want to go to www.cms.gov/cert . On the left hand side of that page, there's a demonstration page. And if you click on that demonstration button and go to the bottom of the page, you will see the slide presentation for today.

So (inaudible) open door forum call that was held in December of 2011 because as some of you may recall, we will originally going to begin this January 1st then it got delayed and so this is very similar, the process and (inaudible) the same.

What we are going to do today is I'll give a 20 –25-minute presentation and then we will open it up for Q&A for the remainder of the call.

So for the purpose of the demonstration is to determine if doing Recovery Auditor prepayment review can help to lower the CMS error rates. We would like to (inaudible). And hopefully (inaudible) to get immediate source of education so that future claims will be billed accurately.

So, in fact, the purpose of the demo, we are going to focus on claims and MS-DRGs we'll try improper payment rates based on the structure of the comprehensive error rate testing program findings. You can find those findings on the CERT program and a long report on the CMS web site on the CERT web page.

We are going to begin this demonstration with the reviews of short inpatient hospital stay. We qualify a short stay, as usually, two days or less. And again, these are the MS-DRGs with the highest error rates as based on the CERT program.

(Inaudible) demonstration project. It will begin August 27, 2012 and it will end August 26, 2015. It is applicable to only 11 states in the country. Those are the same 11 states as we repeated before. They are Florida, California, Michigan, Texas, New York, Louisiana and Illinois, Pennsylvania, Ohio, North Carolina, and Missouri. I will point out, if you are looking at the slide

presentation on slide three, I have Michigan listed twice. That last MI should MO for Missouri and we will be making that correction.

This typical – this type of prepayment review will not be placed to type a prepayment review that goes on as your Medicare Administrative Contractor. However, the Recovery Auditors and the Medicare Administrative Contractors, or MACs, will coordinate so that they are not reviewing the same claims or the same types of claims. And what I mean by that is if a Recovery Auditor is reviewing a particular MS-DRG, then the MAC will not be reviewing that MS-DRG. And that particular hospital may hear from both a Recovery Auditor and a MAC for prepayment review but it should not be on the same MS-DRG or obviously on the same claim.

Slide four of the presentation, (inaudible). As you can see, we only list one start date of August 27, 2012 with one MS-DRGs, MS-DRG 312 Syncope and Collapse. All of the other MS-DRGs will be a released at a time to be determined in the future. We want to begin those slowly and to make sure the (inaudible) provider, MAC and Recovery Auditor perspective.

So over the course of the next four to six months, we will be adding the other seven MS-DRGs that are listed on slide four. We will communicate in advance when these MS-DRGs are available for Recovery Auditor prepayment review through the web site. And if you are familiar with the demonstration web site, we will be creating a special Recovery Audit demonstration page. And it will be on that page that we will announce when a particular MS-DRG is going to go into effect. You should see those changes in the next couple of days. They were going to start them today but I was very hesitant, I didn't want anything happened to the slide presentation.

So you will start to see a singular Recovery Audit demonstration page on – off of the CERT web page. And also something new for this particular demonstration, we are going to create a Twitter hash tag just for the recover audit prepayment review demonstration. Again, this is another way to get out notice that we posted a new MS-DRG to the web site. So that Twitter message, all it will say is, you know, new MS-DRG added, go to the web site.

It won't release the MS-DRG or anything like that. In the message, it will just let you know when you'd like to go to the web page.

The other demonstrations that's going on in CMS are the prior mobility device demonstration. They also are using the Twitter and they seem to think it works well, again, to get information out to providers. So we are going to try it for this prepayment review demonstration also. But, again, it will be very basic and just letting you know when to come to the web site to find out more information.

Slide five (inaudible) operation details of how the demonstration is going to work. It will work very similar to the way prepayment review works today in the Medicare Administrative Contractor world. The additional documentation request will come from the FI or MAC, and will tell you where to send it to. That's going to be very important. Obviously today, you get that notice and you send that record request – those records to the MAC. The MAC has the ability to change the address, and the address to where you will send it to will be the RACs address or the Recovery Auditor's address in there. And you will send your record to the Recovery Auditor for them to review.

Providers have 30 days to send in that documentation. It's very important that providers respond within those 30 days. If the Recovery Auditor does not receive the record, then that claim will be denied and the provider's only recourse will be to appeal the claim and to go through the appeal process. Late documentation will need to be reviewed through the appeal process. It will not go through the (inaudible) Recovery Auditor. It will go through the appeal process.

Recovery auditors will review and communicate the payment determination to the MAC to (inaudible) either proceed with the denial of the claim or with payment of the claim. Providers will receive that determination within 45 days and you will also get – providers will also get a detailed review results letter. So if you are familiar with the review results letters that providers received in a Recovery Audit Program through a post-payment review, you will receive the same type of letter for prepayment review. I do believe this might be somewhat different than the MAC world where you may or may not

receive that written notification, you will definitely get written notification for any claim reviewed by the Recovery Auditor on the prepayment review.

Slide six goes into some more of the operational details. For now, in the beginning, the limits on prepayment and post-payment reviews will typically exceed the current post-payment ADR limits. And what that means is if your current ADR limit for Recovery Auditor post-payment review is 400, then the Recovery Auditor will do their best to make sure that your prepayment reviews and post-payment reviews don't exceed 400.

Now, this may be, I say typically and typically is underlined in the slide presentation because this may be somewhat difficult for several reasons. One, in the beginning, (inaudible) may have already sent out to you your maximum request and so any request that they get in the first couple of weeks of prepayment demonstration may take you over.

Also, Recovery Auditors do post-payment review on 45-day cycles. Prepayment review cannot be in a cycle and so they are also qualified and that is going to make it somewhat difficult in the early stages of this demonstration to make sure they're not exceeding this post-payment limit.

And then lastly, from a prepayment review perspective, the Recovery Auditor is not choosing the claims they wish to review. CMS is choosing the issues or the MS-DRGs. And that claims that are for review will have to be reviewed by a recovery, therefore, those particular claims depending on how much come across per particular provider may cause that limit to go above – to go slightly above that particular ADR limits. So this is going to take us a few months to kind of, you know, give and take a little bit from a prepayment and post-payment side but the Recovery Auditors will do their best to not exceed the current post-payment ADR limits as they're currently set.

Providers may appeal the denial. All initiated appeal rights are there and they stay the same. This is (inaudible) to any other types of prepayment denial. And, again, you know, that first level appeal is heard by the Medicare Administrative Contractor. And any claim that's denied, no matter what the reason is, will go through that first level of appeal.

Another question I was often asked is, what type of review will occur with that claim? That claim will be reviewed in totality for coding issues, for medical necessity issues. It will be reviewed to determine if everything on that claim is correct. And because of this total review, any claim that's reviewed by a Recovery Auditor on a prepayment basis will be off-limits from future post-payment reviews by a CMS contractor. That does not exclude the office of inspector general or Department of Justice or anybody else that – and another governmental agency that might want to review that claim but another Medicare contractor will not be able to review that claim just when a post-payment purpose.

We will highly encourage the Recovery Auditors to post the decisions and these claims for prepayment review on their portals. I do expect providers will be able to find on the portal. But, again, just as this is new for the providers (inaudible), this is new for the Recovery Auditors too. It's another reason why CMS is beginning very slowly to come August 27th and it will not – you're not - provider community is not going to see 100 percent of the first MS-DRG on prepayment review come August 27th.

In fact, the reviews conducted under the prepayment review demonstration, it is not potentially the type of prepayment review that you may think about or may be have known in the past. This is not 100 percent review. This is a review of MS-DRGs for a particular (inaudible) or particular number of claims are going to be reviewed on a monthly basis to determine if they're appropriate or not. That means it's not provider based, as I said several times, this is MS-DRG based. And so CMS is choosing the MS-DRG along with various edit parameters. And in the beginning, it's very basic. As we get in to more sophisticated audits, then we may be able to tailor it and target it by error rates in particular (inaudible) and (inaudible) particular providers.

And one of the questions we're often asked is, well how can a provider get off of prepayment review? Again, because it's not provider specific, it's issue specific, it's really is how does the issue stop becoming available for prepayment review. And that will all be tailored to the CMS error rate for that particular issue. So, if that particular MS-DRG with the error rate goes down,

then CMS may consider removing that from the list possibly replacing it with something else.

Another big question that we get is certainly what's going to happen if there's a MAC transition during demonstration? And the lockout periods that CMS set if they come into play any particular (inaudible) – if CMS (inaudible) ADR request or claim reviews in a particular state because of its transition between one MAC to a new MAC, then the prepayment review would also (inaudible). However, if one CMS gives the go ahead for the Recovery Auditor to begin requesting additional documentation request again, then prepayment review would begin again.

CMS often does that at a point in time the CMS feels is enough time between how long the Recovery Auditor would have to get the records and to review them and the time that claim suggestments could start to begin again. For sometimes that is before what we've said in the past is 90 days before and 90 days after. Sometimes it's actually – ADRs can start before just because of the time it takes to get the records, review the record then actually get the claim out to the Medicare Administrative Contractor to adjust. So that will be a similar process if a transition comes into play in one of the state – in one of these 11 states.

That was a lot of information in a very short period of time. But with that, (Ryan), we will go ahead and open up for the Q&A session.

Male: Hello, (Ryan), the operator.

Operator: At this time, if you would like to ask a question, please press star one on your telephone keypad.

Your first question comes from the line of (Janine Schultz). Your line is open.

Again, (Janine Schultz), your line is open.

Male: Let's take the next caller.

Operator: Your next question comes from the line of Liz Milton. Your line is open.

Liz Milton: Yes. I have a question, it appears from what I heard in this presentation that we're talking here about flagging of the DRGs. Is there going to be any filtered down to the skilled nursing facility level on this RAC demonstration study?

Connie Leonard: At this time, the only claims selected for prepayment review will be short inpatient hospital stays. So it will not affect the skilled nursing facilities.

Liz Milton: Thank you.

Operator: Again, if you would like to ask a question, please press star one on your telephone keypad.

Your next question comes from the line Susan Emanuelle. Your line is open.

Susan Emanuelle: Yes, hi. I have two questions about the appeal process. One, what actual documentation or communication starts the appeal processes, is it receipt of the review results letter? And then my second question, is there going to be also opportunity for a discussion period with the RAC auditor?

Connie Leonard: The appeal timeframe begins with the receipt of the remittance advice or the receipt of the denial. And I apologize if I'm getting that terminology incorrect from a prepayment perspective. But I'm going to assume here that there is still a denial, you'll see the remittance advice which denies the claim. And that's what actually starts the appeal right. It's not the review results letter.

So hopefully with prepayment review, they will come very close together since the timeframe for payment are necessary. And from a discussion period perspective, because of the timeframes that CMS has to make payment, there will not be the ability to have a discussion period at this time. We would certainly like to be able to add that in. And if we could figure out how to add that in still the following normal, we have to pay the claim within a certain amount of time, we would certainly be open to that. But I am certainly open to ideas.

And I failed to mention that on slide seven, we do have contact information and a RAC@cms.hhs.gov e-mail box that we'd be more than happy to take

ideas about how we could incorporate the discussion period into the prepayment review demonstration. But so far, we haven't come up with the correct way and once the denial happens, (inaudible).

Susan Emanuelle: OK, great. And then, Connie, does that mean that if they don't – because you had mentioned the time period and because it is an abbreviated time period that we're doing the review in, I know that on MAC prepayment reviews, we often run in to situations where the MAC will reach the expected timeframe and they haven't completed their review yet. So they'll go ahead and release the funds with the caveat because they may review it later. Do you expect that same type of confusion with this as well or what happens if we reach the time period that the RAC has to review the record and they haven't completed the record yet? Will they also release the funds?

Connie Leonard: I do not expect that scenario to happen but if for some reason it did happen, then the recovery auditor will not be able to then review that claim from a post-payment perspective which is basically what that is at that particular point so payment will have to be made.

The timeframe is will need to be adhered to by the Recovery Auditors. And they actually are being placed in their recovery auditors contract to appear at their specific timeframe.

Susan Emanuelle: Perfect, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of Jill Zimmerman. Your line is open.

Jill Zimmerman: Hi, I wanted to know if the correspondents that we're going to receive the review results letters, are they going to be sent to the current RAC coordinator or to a different person at our facility.

Connie Leonard: The recovery letters – we'll send the review results letters to the point of contact that they have on hand. If a facility wants to designate someone separate just for prepayment review, they should contact the recover auditor.

And I believe they would be able to accommodate you but the expectation would be that it would go to the point of contact that the Recovery Auditor currently has on hand.

Jill Zimmerman: OK, and I have one other question. Will the notifications or review results letter be clearly marked that it's a prepayment review?

Connie Leonard: Yes, we can certainly make sure that they are designated that this was a prepayment review. Yes.

Jill Zimmerman: Thank you.

Operator: Your next question comes from the line of Rebekah Willis. Your line is open.

Rebekah Willis: I have two questions. The first question is the 45 days that you stated for the review, are those going to be the same as in the calendar days or are you going to do 45 business days?

Connie Leonard: It is 45 calendar days. Thank you for that clarification.

Rebekah Willis: OK. And then the second question is we are currently in the process – we're in Michigan so we're currently changing the fiscal intermediary. So from what you stated, does that mean that CMS probably won't send out any of the ADRs for the prepayments until towards the end of the blackout or we shouldn't expect any by August 27th?

Connie Leonard: I believe that in Michigan because the transition would have already occurred that it is beginning on August 27th. We will try to clarify on the web page effective dates for each states that are undergoing transitions. Right not, I certainly know that Texas, Michigan and Louisiana are probably going through some sort of transition. And maybe some others, I don't mean to forget them. But for Michigan, I believe it will start, because the caveat auditor has already happened that prepayment will start August 27th.

Rebekah Willis: Thank you.

Operator: Your next question comes from the line of Robin Price. Your line is open.

Robin Price: Yes. I have a couple of questions. My first one is you talked about how the review results letters or the issues would be posted to the provider page. Will the RACs (inaudible) list the claims on the provider page the same way we are able to track for our post-payment claims?

Connie Leonard: Yes. CMS is going encourage the Recovery Auditors use the portal for prepay the same way they use it for post-pay.

Robin Price: OK. And then my other question is you said on notification or the time it would start for the appeals with the RA, will they still have the N432 or N469 RA code on those claims or able to identify them?

Connie Leonard: I believe they will but I will clarify that and we'll get some Qs & As for the questions that we can't answer today up on our web site. I believe it will but I'm not 100 percent so I'll clarify that and put that up on the web site.

Robin Price: OK. And my last question is currently right now with the post-payment, if appeals are found favorable, we do not receive a paper letter or a letter of notifications. How will the overturned decisions or the favorable appeals, would they just be paid out or we receive something or will we still have to do the same (inaudible) its tracking what we do today?

Connie Leonard: What state are you in?

Robin Price: North Carolina.

Connie Leonard: OK. And you don't get letters for when you get a favorable appeal?

Robin Price: No.

Connie Leonard: That's interesting. That data is very MACs contact specific so let me check to see what's the MACs are doing from a prepayment appeal perspective to see if there's notification or if you're going to have to watch and (Inaudible) the RAs. That's a good question, thank you.

Robin Price: Thank you.

Operator: Your next question comes from the line of Stewart Presser. Your line is open.

Stewart Presser: Hey, Connie. I have two questions for you. The first one is with the start date of 8/27, is that just calendar date 8/27? Is it reference by discharge date, admit date or any claim coming into the MAC as of 8/27?

Connie Leonard: Hi, Stewart. It's going to be any claim coming in as of 8/27.

Stewart Presser: OK. The second one troubles me in that if a hospital is already at its ADR max like for example, the large academics and now it's 600 every 45 days. So what I heard you say was, in the beginning it will be a little shaky and that they may go over that limit because the MAC won't know that they are at a limit of 600 already. Is that correct? So let's say they process 100 – just for argument sake, 100 DRG on an syncope in one day. How will they know how many of those hundred will get flagged for prepayment review by the RAC? And how will the MAC know that they've already received 600 ADRs from the RAC three days ago?

Connie Leonard: (Inaudible).

Stewart Presser: So I don't understand how even after a couple of months you're going to be able to have the MACs build in their system that this provider is at MACs ADR limits.

Connie Leonard: It actually is going to work. It will have to work the reverse because you're right. There's no way for the MAC to know and for the MAC system to know that a provider has reached, you know, their volume on post-pay side. So really what we're going to have to do with the Recovery Auditors are going to have to do is, you know, once we can see the volume of prepay, you know, based on a particular (inaudible) and MS-DRGs that we put in, then they're going to have to start eliminating the post-pay reviews so that they can be sure that we're not overseeing or, you know, reaching over, you know, that limit, you know, whatever their maximum limit is.

And, you know, Stewart, I know you have a lot of the larger facilities with a $600 limit up in your area. And please, you know, any provider that – and especially in the first couple of months that is having difficulty because of a number of ADR request, please reach out, you know, to the RAC to get

(inaudible) on the post-pay lines. Again, I qualify that on the post-pay side. And we will make sure the RACs (inaudible) especially in the beginning. They usually are always very willing to grant that and for some reason they're not, you know, please come to me. But we will make sure especially in the beginning that they are more than willing to grant that extension if a provider is receiving too many prepay and post-pay and certainly can't handle it at all.

Stewart Presser: OK, well that's fair. The last question, so I heard you say that the MACs will just indicate in their ADR letters instead of sending the chart to the MAC, they will just put additional language in there to send the chart to the RAC auditor. So I assume the ADR letter would be the same that a hospital gets on a MAC prepay or a RAC prepay other than the address would be different.

Connie Leonard: You're correct, yes.

Stewart Presser: OK. And lastly…

Connie Leonard: (Inaudible).

Stewart Presser: You're giving the RACs 45 days to render a decision if they go over that and the claim is valid? Is the provider entitled to any interest? Because it's past the timeframe of a clean claim.

Connie Leonard: We're actually given the RACs a little bit less time just to allow for, you know, time to make sure we meet that 45 days time – day timeframe. And it was my understanding that if a decision is not made in that particular timeframe, then that's the way the (inaudible) is set up that the claim will be paid. So we would never get to an interest situation.

Stewart Presser: OK, thank you very much.

Connie Leonard: Thanks, Stewart.

Operator: Your next question comes from the line of Mary Kate Stinneford. Your line is open.

Mary Kate Stinneford: Yes. I just wanted to ask and this might be a followup to something somebody already asked. But in the original open door forum on

this it was mentioned that there would a separate NC code to identify prepay from post-pay. Is there – do you have any information on that?

Connie Leonard: I do not and at this time my memory is failing at this time. I don't remember that coming up. But I will definitely look into it and add this question on to our web site. And we'll definitely try to get this Q&A document up next week.

Mary Kate Stinneford: Thank you.

Operator: Your next question comes from the line of Brand Martin. Your line is open.

Brandy Mortn: Yes, I have a question. Will we be able to identify this and DDE the way we can identify the MAC prepay?

Connie Leonard: (Inaudible) you will be able to.

Brandy Mortn: Do you know the reason code?

Connie Leonard: I do not know the reason code it's because it's very well maybe the same reason code that the MACs use for MAC prepay. They may use the same for a RAC prepay, or Recovery Auditor prepay.

Brandy Mortn: Oh, OK. Thanks.

Operator: Your next question comes from the line of Melanie Graham. Your line is open.

Melanie Graham: Hi, Connie, how are you? I have a few questions for you. My first question is will the RACs get paid the contingency fee for this prepayment reviews?

Connie Leonard: Yes, the RACs will get – the Recovery Auditors will get paid the same contingency fee that they get for post-pay.

Melanie Graham: OK. And you mentioned the, you know, that the CMS had chosen the MS-DRG so they're not based on providers. Does that mean that the RACs are pretty much just going to peak the syncope and hit every hospital that uses that DRG?

Connie Leonard: No, in fact, Recovery Auditors are not choosing the claims. They actually have to review on any claim that CMS gives them. And CMS, at least at this time, and we may get more sophisticated as the demonstration goes on. But at this time, we will just picking if there is a (inaudible) percentage of this particular MS-DRGs to get prepayment review. Now, we certainly hear from providers. We hear (inaudible) in the post-pay perspective and I'm sure we'll hear in the prepay perspective too that ideally CMS would be able to, you know, target only providers that has higher rates themselves within this higher rate of MS-DRGs. And that is the direction that we (inaudible) to get to so that a particular provider who does not have a higher rate – I mean, if (inaudible) MS-DRG would not necessarily be impacted as much as someone who does have a higher rate. But that is not wherever at yet.

So in the beginning, it will be CMS choosing a small percentage of all the claims that come in for syncope and having them reviewed by the Recovery Auditor. And they will not have a choice. They actually have to review these claims for prepayment review that CMS sends them.

So if you can imagine, it's very – the Recovery Auditors are going to want CMS to tailor, you know, these reviews too because they want to review claims where they might be a high probability of an improper payment.

Melanie Graham: OK. OK. So – and my last question is, I know you mentioned on one of the slides about, you know, MACs and RACs sort of coordinating their efforts. But one of our concerns is, you know, we have a lot of MAC reviews going on on post-payment, prepayment. And one of the things that we want to ensure them, we're curious of how CMS is going to handle it is how are – what processes do you have in place to make sure that the MACs are not going to hit the same claims that the RAC is or, you know, as this moves forward?

Connie Leonard: Well, one way they were able to make sure they're not hitting the same claims from a prepayment perspective is the MAC is the one that's going to be inputting the (inaudible) into place and transferring the data to the Recovery Auditor. So from that perspective, they're going to know which MS-DRGs,

the RACs, the recover auditors are looking and which MS-DRGs they're looking at. And that's why we're doing on MS-DRG perspective and not a claim perspective. We don't want (inaudible) providers to get a prepayment request from a MAC and a Recovery Auditor. (Inaudible). That will get off (inaudible) complicated for the providers. So by limiting it to particular MS-DRGs, we feel that the MACs and the Recovery Auditors can be sure that they're not reviewing the same particular claims.

But as you pointed out, a provider may very well hear from a MAC and a Recovery Auditor at the same time for prepayment review just on different MS-DRGs. And, you know, – and obviously, there isn't much we can do from a prepayment perspective but if a particular provider is getting caught up that they have, you know, a lot of prepayment reviews from the Recovery Auditors and the MAC, as well as additional documentation request from a post-payment perspective. So please contact the Recovery Auditor from a post-payment perspective to request an extension. And as you can imagine, you know, there is going to be close communication as there already is between the MACs and the Recovery Auditors. And if a particular MAC just have a particular facility of a high rate of prepayment review, then we will firmly ask that they share these entities with the Recovery Auditors so that we can be sure that we're not, again, (inaudible) doing additional prepayment review on this particular facilities.

Melanie Graham: (Inaudible).

Connie Leonard: And I'm – I think providers already do but certainly, you know, CMS always (inaudible) from a RAC perspective, we have the points of contact for each region on our web site. And certainly if there are any issues, you know, feel free to contact CMS, you know, yourself or your association in (inaudible), you know, whatever means that you need to. (Inaudible) feels CMS needs to intervene one way or the other.

Operator: Your next question comes from the line of (Charita Monson). Your line is open.

(Charita Monson): Yes. I wanted to ask to see that you could repeat those web sites where we could locate today's slide and then also the web site that has the updated information for this demonstration project.

Connie Leonard: Sure. It's going to be http://www.cms.gov/CERT . And once you get to that web page, on the left hand side, there is a link entitled "Demonstration". And on that page, all the way through the very bottom under download, it's the only thing on the page for download is for slide presentation for today. And that's the same page where in a day or so, there's going to be a special just recover audit prepayment review demonstration web page. And that's going to be the web page where we're going to list the MS-DRGs and the Q&A document in some of (inaudible) document.

When you go into the page right now, you will see that there is a separate web page for the PMD demonstration and the Part A to Part B Rebilling demonstration. And we will just be creating another web page specifically for this demonstration so that we can update the providers with this information.

And for some reason anyone can't find it, if you just send an e-mail to the rac@cms.hhs.gov e-mail box, we'll be glad to send the link to you.

(Charita Monson): Thank you very much.

Operator: Your next question comes from the line of (Terry Anderson). Your line is open.

(Terry Anderson): Yes, I have a couple of questions. Did you say that the ADR will be coming from the FI or MAC? Is that correct?

Connie Leonard: Yes, it is. It is.

(Terry Anderson): OK. So will we be able to direct that specifically to a RAC coordinator?

Connie Leonard: It is my understanding, you may. Again, my limited knowledge of the prepayment process, my understanding was a lot of this (inaudible) electronically to them. And that it was in the system that they will request

(inaudible) and change the address to be the address of the Recovery Auditor and not the MAC.

(Terry Anderson): OK. Because currently, we received, you know, the claim go to a pending status. And then we do receive a letter in the mail from our FI at this point. So I guess the second question is, we are an Illinois hospital but have our FI in the Wisconsin – in the Wisconsin which is not part of the 11. So will we be considered part of this project?

Connie Leonard: OK. You have your MAC or FI is currently WPS?

(Terry Anderson): Yes, that's correct.

Connie Leonard: OK. Let me clarify that question on the (inaudible). You know, I still probably and just treated that it is only for the state of Illinois but we will get a better clarification for (inaudible) for the WPS providers up on our web site. Thank you.

(Terry Anderson): Thanks. That's it.

Operator: Your next question comes from the line of (Inaudible). Your line is open.

Again, (Inaudible), your line is open.

(Slow Rate): OK, sorry. I was just wondering how will we distinguish between a coding issue versus medical necessity issue?

Connie Leonard: (Inaudible) the review results letter that the Recovery Auditor will send – to be very detail with us (inaudible), let's say, coding issue or a medical necessity issue.

(Inaudible): OK. So it won't be like automated versus complex, it will have to read the letter to see what it is?

Connie Leonard: Right. I would think that you would read the letter. Now, you may be able to determine some things dependent on how claim is adjusted but your primary patient information as to why the claim is adjusted and how it was adjusted is going to be through that review results letter.

(Inaudible): OK, thanks.

Operator: Your next question comes from the line of Reza Monisterio. Your line is open.

Reza Monisterio: Hi, I have a question on the prepayment. If a case is, for example, prepayment will the doctors be also be paid or held their payment?

Connie Leonard: Right now, this – the prepayment demonstration is only on the inpatient hospital claims. We are not expanding the prepayment review at this time to any other associating physician for Part B claims.

Reza Monisterio: OK, thank you.

Operator: Your next question comes from the line of (Adel Gile). Your line is open.

(Adel Gile): Hi. Mine was about the cross claims review, if this is so effective with other audits. I'm just surprised we're not doing it this time because it's really – it really made a big difference. So, thank you.

Operator: Your next question comes from the line of (Brenda Chang). Your line is open.

(Brenda Chang): Hi, Connie. I'm back to the ADR is currently at our hospital with the MAC prepayment. When we received the main ADR, sometimes we will receive the letter requesting the medical records. Other times, we have to find out on the DDE that they have requested records. Should we do the same thing with this RAC prepayment to be on the lookout through the DDEs to see that records have been requested and not depend on the letter?

Connie Leonard: I would, yes, because it is my understanding that most MACs are using the DDE systems and that's how they communicate if they're doing prepayment review. But, again, because this is obviously such an important piece of the project, we will clarify this. And if there are any abnormalities with any particular jurisdiction on a particular, then we'll be sure that we get this out there on the web site so that people know because this is obviously an important piece to know how you're going to get this request.

(Brenda Chang): OK. Thank you, Connie.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Lisa Scott). Your line is open.

(Lisa Scott): Hello, Connie. You just answered part of my question. I'm very concerned because in our jurisdiction, we're not receiving correspondence from our MAC in a timely fashion. A lot of the correspondence gets lost. Therefore, I'm very concerned that we are not going to be receiving the medical record request in a timely fashion. So anything you could do to remedy that would be most appreciated because I imagine we're going to be having a lot of late medical record request and therefore receiving denials.

Connie Leonard: And you're getting – and you currently get some anything from prepayment review through the mail?

(Lisa Scott): Very rarely. Very rarely.

Connie Leonard: Do you get it through the DDE system at all.

(Lisa Scott): Yes, we do. We get a request through the DDE for our MAC prepayment.

Connie Leonard: OK. And I don't know if you've had any Recovery Auditor correspondence. Have you have any a recovery correspondents?

(Lisa Scott): Well, yes. The medical record request comes from Connolly at this time but I understand that now the prepayment RAC will be coming from our MAC. Those medical (inaudible).

Connie Leonard: No, I was just trying to determine if you're getting your Recovery Auditor correspondence because, you know, again, we don't know – I thought that everything was going to come to the system but if there is a need for paper ADRs then we certainly let you could have those sent by the Recovery Auditor. And I'm just curious if you're receiving your Recovery Auditor correspondence in a somewhat timely manner.

(Lisa Scott): Yes, we are. So that would be great.

Connie Leonard: OK.

(Lisa Scott): If the request could also come from Connolly as well.

Connie Leonard: OK. Thank you for that suggestion. And we'll definitely try to figure out exactly what, you know, each of the MACs do. And then, again, we want this (inaudible) perspective the MACs, the Recovery Auditors and then providers. So, you know, if we need to implement something new to make sure you guys are doing things timely, we certainly can. Thank you.

(Lisa Scott): Thank you.

Operator: Your next question comes from the line of (Keith Price). Your line is open.

(Keith Price): Yes. If our facility is part of the A/B Billing demonstration, can we still go to the appeal process for the prepay reviews?

Connie Leonard: If you – if the claim that is denied is (inaudible) you and it falls under the A/B rebilling then we'll only be able to rebill. You will not be able to go through the appeal process for this demo. So there are some claims that could overlap but we expect to be somewhat rare.

(Keith Price): OK. And I have one more question about the ADR request. Will those be…

Connie Leonard: Yes.

(Keith Price): We're kind of getting conflicting, will they come electronically or will we get a paper request for the medical records?

Connie Leonard: My understand was that it was going to be electronic but I'm obviously hearing from some providers today that sometimes they get electronic and sometimes they get paper. So I really need to get clarification and so we'll post something to the web site next week once I can get firm communication because I really (inaudible) think everything was going to be electronic.

(Keith Price): OK. Will there be instructions on how you want those whether it be paper form or can we load them on to a CD or…?

Connie Leonard: (Inaudible) the record?

(Keith Price): Yes.

Connie Leonard: Yes. I (inaudible) know you're going to be sending this to the Recovery Auditors and Recovery Auditors certainly would love to get the (inaudible) on CDs. (Inaudible). So if that's how you've been communicating with your Recovery Auditor, certainly, you know, continue to use the CDs and the paper. But we can make sure we post that too.

(Keith Price). OK. Thank you so much.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Emilia Bryant). Your line is open.

(Emilia Bryant): Good afternoon, Connie. I hope you're doing well. There's a number of folks in front of me who's talked about the identification of the RAC prepayment review. And one of the tentative responses was that she thought that the status location that would be used in the (inaudible) or DDE system might be the same as the one that is used by the MACs for their prepayment review. They found a number of issues with regard to keeping track of this separately knowing who's accountable. And also I understand from some others that the need for communication not necessarily being exactly the best in the world sometimes. I would highly consider your – you guys going back and looking to make certain that this was a different status location than the MACs prepayment review. It will help the community and help you guys in the long run.

With that said, thank you very much.

Connie Leonard: Thank you, Emilia. And I think that's a great suggestion. And I'm sure everyone realizes, we may not be able to have, you know, that separate reason code or status code, you know, right away in the beginning but we'll certainly

see what we can do to create a separate status code in the DDE system for RACs prepayment review. So we'll certainly (inaudible) and see what can be done. Thank you.

Operator: Your next question comes from the line of (Rob Canter). Your line is open.

(Rob Canter): Oh, thank you for taking my call. Most of my questions have been answered. I do have one clarification questions and that's regarding the ADR limits. One of my hospitals right now, for example, has a maximum post-pay RAC request of 400 cases. So the prepay and post-pay RAC requests will not go over the 400 requests combined, correct?

Connie Leonard: That is correct. Now, I qualify that to say that in the beginning because it may go over slightly just as we're trying to get a handle on the prepay volume and some like, for example, that facility might have already reached their 400 limit for this 45 days cycle. So it is possible in the beginning that we go over that but within a couple of months, we should be able to make sure that the limit combined is not exceeding that 400. And if your facility or any of your facilities gets, you know, caught up because the (inaudible) request certainly contacts the Recovery Auditor to take an extension on the post-pay ones. We'll certainly be more than willing to grant those especially in the first couple of months.

(Rob Canter): All right, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Brad Langston). Your line is open.

(Linda): Hi, this is actually (Linda). And most of the questions had been answered. But one question I have, is there any possibility that a request could come from the RAC on a prepayment review for an adjusted claim as oppose for the initial new claim that had been sent?

Connie Leonard: That's a good question and I believe the answer is certainly yes. But we will clarify that and get it up on our FAQ or Q&A list. I would think it depends on

how we instruct the audit but right now I'm thinking the answer is probably yes, it could be for an adjusted claim.

(Linda): OK, thank you.

Operator: Again, ladies and gentlemen, if you would like to ask a question, please press star one on your telephone keypad. If you would like to remove your question from the queue, please press the pound key.

Your next question comes from the line of (Terry Hill). Your line is open.

(Terry Hill): Yes, thank you for taking my question. Just a clarification on slide number five where you indicate providers will have 30 days to send the documentation, is that based on the letter date or the date that the letter was received – the request was received.

Connie Leonard: It's going to be 30 days from the letter date or the date of the electronic communication as they send the DDE system.

(Terry Hill): Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Carrie Emig). Your line is open.

(Carrie Emig): Thank you. My questions have been answered but I just would like to say that we would prefer to have a paper copy of the ADR in addition to it coming over the DDE. You know, just to let you know.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Tina Brown). Your line is open.

(Tina Brown): Hi, I was just wondering, we are a critical access hospital, so I'm wondering how we would be affected with this. Would it be the same as the RACs or – because we don't get reimbursed based on DRGs?

Connie Leonard: Correct but critical access hospitals are inputted under Recovery Audit review usually from a medical necessity perspective. And so again, if it's I say that today is (inaudible) if it is possible that a critical access hospital could be part of this demonstration.

(Tina Brown): OK. That's what I assumed. I just wanted to make sure.

Connie Leonard: Not a problem, thank you.

(Tina Brown): Thanks.

Operator: Your next question comes from the line of (Sharon Easterling). Your line is open.

(Sharon Easterling): Hello, Connie. How are you today? My question relates to the 45-day timeframe for the RAC review to occur. What exactly logistically is going to happen if it's past the 45 days? Is there going to be auto pay at day 46? And what's the recourse of the provider if the review isn't happening as it should until they contact the region project officer or it should happen at that date?

Connie Leonard: Yes, my understanding is that it is an auto pay at day 46, you know. Because if the record does not get – if a decision is not answered, you know, (inaudible) to pay the claim or deny the claim but the system is set up to automatically pay the claim after that 45-day period time. So if a provider is seeing situations where they are not getting decisions, then yes, you know, this is something that CMS wants to know and contacting your regional – your regional counterpart here at CMS or myself would be perfectly fine. And because we do expect the RACs to meet all this timeframe.

Operator: Your next question comes from the line of (Jo Caverdoe). Your line is open.

(Jo Caverdoe): Yes, I have a question as far as the medical necessity side. Since these are short days, if it's changed due to wrong place of service such as it should have been done outpatient, what recourse do we have for rebilling? Are we going to be limited to ancillaries? Is that going to be what's paid the adjusted side when we do receive payment? Or how is that going work?

Connie Leonard: Yes, this will happen just like it would happen in the (inaudible). Meaning that that claim would be denied in full and then you would have to rebill for the ancillary services unless you are participant in the demonstration – in the A/B – Part A to Part B rebilling demonstration, you would only be able to rebill for the ancillary services.

Operator: Your next question comes from the line of (Margo Heinz). Your line is open.

(Margo Heinz): Hello. Most of my questions have been answered but just a followup on the limits for prepayment and post-payment reviews not exceeding the current post-payment ADRs and the provider's recourse is to notify their RAC and ask for an extension on the prepayment. Will those that they extend go into the next 45-day period so that we don't continue to build up?

Connie Leonard: Just as to clarify, make sure you're requesting an extension on the post-pay (inaudible). All right, I don't think an extension will be granted on the prepay but from a post-payment perspective.

(Margo Heinz): Right.

Connie Leonard: And we can certainly – I don't know if they would (inaudible) (inaudible) next 45-day period of time but again in that next 45 days cycle, the Recovery Auditor will have a better understanding of the prepay volume and then make sure that they're not going to exceed the limit be it 400 or whatever it is, you know, that particular cycle.

And again, you know, the Recovery Auditor (inaudible) we'll work with the providers but the most important thing is to keep the line of communication open and (inaudible) if you're experiencing difficulty because of the, you know, new demonstration that's coming (inaudible).

(Margo Heinz): OK. And my next question is – you said that they're going to be doing a percentage of reviews on those short stays to begin with. Can we expect all providers to get a percentage of all of their post, you know, their short stay reviews so that we can anticipate what we're expecting to get called on?

Connie Leonard: Well, I definitely think that at some point in time, you know, every provider will get a request of some sort. I do expect the volume to be relatively low from a provider perspective. So I do not expect especially in the beginning when there's just one MS-DRG that, you know, that is going to (inaudible) a particular facility. You know, we don't, you know, know this fact percentage so I can't say that, you know, every single provider is going to hit – get hit the 10, 15, 25 percent of these claims.

But, you know, I can certainly say that, you know, every provider will not be – is not 100 percent review of all of these MS-DRGs so every provider should not expect to be getting a ADR request on every single, you know, short stay that they put in to the system.

(Margo Heinz): OK, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Gail Shin). Your line is open.

(Gail Shin): Will you post the instruction for the A/B rebilling demo what we are allowed to do?

Connie Leonard: Absolutely. We'll make sure we have links of the prepay demonstration page to the appropriate FAQs on the rebilling. And if we need a couple more, we'll actually add a couple of more too. It's not a problem.

(Gail Shin): Thank you.

Operator: Your next question comes from the line of (Sean Green). Your line is open.

(Sean Green): A majority of my questions have already been asked but I would say that we do need a way to identify ADR's electronically and distinguish between the MACs and RACs as they are submitted because that's a huge problem for providers that have – or for systems that have multiple providers.

Connie Leonard: OK, thank you.

(Sean Green): You're welcome.

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

(David Smith): Hi, I had a couple of questions. One, I guess, maybe (inaudible) we'll they still be continuing to pay for the mailing and the shipping and the copying associated with the prepay chart? And do they also cover if one of our people mailed it to the wrong place because it looks like the same request?

Connie Leonard: That's actually a great question. And (inaudible) I cannot remember what we decided about payment for record for prepay. So I will definitely – we will definitely get that answer posted on to the web site early next week because that's a wonderful question. And I'm sure it's on the minds of lots of providers that are out there.

Typically, you get paid once for the record but in the instance that a provider accidentally sent it to the MAC, the MAC will forward it to the Recovery Auditors. The provider should not have to send a second record.

(David Smith): OK. Well, that's good. And you mentioned that the RAC is very tolerant of being able to change some of the dates or getting extensions or whatever. I was wondering if the MAC is ever tolerant with regards to limits. Our particular MAC seems to be quite fond of this prepay review also. And sometimes there are conflicts associated with our ability to fulfill their request. And I guess, finally, has anyone ever considered that perhaps the MAC should also use the same system as the RACs too if they have a problem with a particular chart? They send us correspondents to explain it or denying something because of this, this, and this. I mean, that's a great educational tool.

Connie Leonard: Yes (inaudible) and CMS is actually undergoing an initiative to make sure the types of correspondence that comes out from all of our different contractors that conducts medical review to make sure that correspondence is more (inaudible). Because we have lots of different versions of review results letters and additional documentation requests and CMS (inaudible) is actually working on an initiative right now to try to consolidate and then make sure a lot of those are the same because we do and we're providing good information to the providers, you know, in this letters. Hopefully in the future, you'll see

some changes to make sure that your detailed review results letters across the board.

(David Smith): Oh, that would be very nice. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Carol Kendall). Your line is open.

(Carol Kendall): Hello, I have two questions. One has to do with your comments about not having duplicate effort. I was writing very quickly but my notes say that they would not be reviewed with the same DRGs certainly not the same claim. So are you saying that if our MAC is already reviewing, for example, DRG 312 that that would not – that they would stop that and it will be part of the RAC prepay review only?

Connie Leonard: Correct, yes. Obviously, we'll be sharing the list of MS-DRGs with the MACs. And if a MAC is currently undergoing a prepayment review for that particular MS-DRG, they will stop after there – through there, you know, latest round of record. And then the Recovery Auditor will begin reviewing it and the Medicare Administrative Contractor will review another MS-DRG. So we will not have the Medicare Administrative Contractor, or MAC, reviewing the same MS-DRGs as the Recovery Auditor.

(Carol Kendall): OK, thank you. And one other question, is it possible we would get request for records based on Medicare secondary payers – if Medicare is the secondary payer, sorry?

Connie Leonard: I would not expect to. We – that's a very good question. And probably sometime we should make sure we have added into our edit parameters but typically the Recovery Auditor does not review a Medicare secondary payer situation.

(Carol Kendall): OK, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Karen Freetake). Your line is open.

(Karen Freetake): Good afternoon. Will you give us some information about PIP Hospital, the Periodic Interim Payment? Will they be involved in this prepayment audit program?

Connie Leonard: My expectation is yes. They will be involved in the demonstration.

(Karen Freetake): OK. If so, we have some problems with the retrospective audit in terms of not receiving a demand letter and not understanding when a payment would actually be retracted. In the case of the PIP hospitals, how will we know if a payment, you know, is going to be held or if the cases passed if we do get payment or there will be special edits or some kind of something that will show up on the RA?

Connie Leonard: That's a great question. And you're right, CMS has been, for the last couple of months, trying to put in some system changes, you know, to allow PIP hospitals to get that recognition and to get that notification as to when a post-payment review is occurring. And we would want the same type of notification to go out from a prepayment perspective. And if those changes aren't going be enacted anytime soon then we may have to delay PIP hospitals. So we'll clarify that in our Q&A document once I can get a handle on how, you know, what the current processes for PIP hospitals and (inaudible) our hopeful fix is going to go in so that you guys will get a (inaudible) notification that we've been trying to put in the system.

(Karen Freetake): Oh, thank you. (Mary) was (inaudible).

(Mary): The only think I hope I wanted to confirm is that if we do get a denial – prepayment denial that we need to file the same rebilling procedures as we would that we would have to bill the (inaudible) type and the limited (inaudible) codes?

Connie Leonard: That is correct. You would only be able to rebill for the ancillary services.

(Karen Freetake): All right, thank you very much.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Regine Scott). Your line is open.

Again, (Regine Scott), your line is open.

Your next question comes from (Bethany Johnson). Your line is open.

(Bethany Johnson): Yes, we were wondering when the (inaudible) from the 45 days for the Recovery Auditors to review. Does it start with the time they received our record or the day after the record was due?

Connie Leonard: It will start on the day they received the record.

(Bethany Johnson): OK, thank you.

Connie Leonard: I will clarify that because the 45 days, again, that's a very system oriented statutory timeframe. So we will – I do want to make sure that I'm correct and that – but we will verify that and make sure we get some (inaudible) Qs & As up there on a process. But I believe it's going to start on the day they received the records.

(Bethany Johnson): All right, thank you. And I just wanted to echo a comment made by one of the earlier callers. We also we do not receive a letter when there's a favorable decision on the first level appeal. And we are in a state of Illinois.

Connie Leonard: Thank you for that feedback. I appreciate it.

(Bethany Johnson): All right, thank you.

Operator: Your next question comes from the line of (John Harish). Your line is open.

(John Harish): (Inaudible). Hello.

Connie Leonard: Is there a question?

Operator: (Inaudible) Harish, your line is open.

(John Harish): OK. Can you hear me?

Connie Leonard: Yes, we can.

(John Harish): Oh, I'm sorry. I think (inaudible). First I'm making observation, throughout your presentation, you talked about how the RAC will be (inaudible their best in doing what they can to meet their deadlines and meet the limits. Yet with hospitals around the country, we try our best and do what we can base on an inpatient admission on a (inaudible) time line and medical necessity, we are penalized for it. And I think that's blatantly wrong.

The second question is, you know, RACs – my real question, in RAC demonstration project, they received their down key payments whether or not they were from – they're appeal was successful enough to denial. Would that could be the same here or will they only get paid at the end if there's no over (inaudible)?

Connie Leonard: Yes, when we implemented a national program, we did change that to now Recovery Auditors only get (inaudible) if it is not overturned at any level of appeal. And that will stay the same with the prepayment demonstration. They will only get (inaudible) that is not overturned at any level of appeal.

(John Harish): (Inaudible).

Connie Leonard: Thank you.

Operator: Your next question comes from the line of Susan Emanuelle. Your line is open.

Susan Emanuelle: Yes. How will you report out results for the demonstration and how often will you be reporting it out? And then I have a followup question after that.

Connie Leonard: I expect that we will include information about the demonstration in the annual Recovery Audit report to congress that we do release annually. And it is possible that as some of you may now, CMS has (inaudible) to put just Recovery Audit Program information on the web site on a quarterly basis. So we put out correction information as well as the top issues and just recently

some appeal information. And it is possible that we may do that with the demonstration but I would expect at the minimum in the annual reports congress.

Susan Emanuelle: OK. OK. So just annually. I also will have the same followup question that I think I heard you were going to address and that's how favorable appeals would be identified. We have facilities in California, Nevada, and Arizona and we also don't get notification from our MACs on favorable appeals. So…

Connie Leonard: Thank you.

Susan Emanuelle: (Inaudible).

Connie Leonard: Thank you for (inaudible). I'm interested to know that it's not – it doesn't seem to be just Illinois. So we would definitely certainly look into that. I thought that was one piece that was (inaudible) because we certainly understand the need and the want of providers to receive that type of favorable documentation. So we will get clarification from the appeal area here in CMS to determine what the current practice is. And if there's anything we can do at least from a prepayment demonstration perspective. Thank you.

Susan Emanuelle: Yes, perfect. And my last question was from an education standpoint then for the health systems. Obviously, syncope appears to be, you know, a target area for a reason. What type of recommendations do you have for facilities and that maybe aren't successful during the prepayment review process on where they can go to get good information from you on what we should be changing or how we should be doing things differently?

Connie Leonard: One of the things that we want to do and we want to have out shortly after we begin the demonstration is special (inaudible) articles on each of these particular MS-DRGs to give providers some guidance and some examples of what they should have (inaudible) and where they can go to get more information so that – it's actually a great question. I did mention that before but if we already don't have plenty of topics in our PCG compliance newsletters that we do on a (inaudible) basis or some of the special (inaudible) matters articles that we've already done to the post-payment process. We're going to be doing that series on special (inaudible) articles just from a

particular MS-DRGs that have higher rates and that we're looking at from a prepayment perspective.

Susan Emanuelle: Great. And then they'll post those to the prepayment demonstration web site?

Connie Leonard: We will. We'll include a link to these articles once they're posted. And, again, we will, you know, make sure that you guys, you know, have noticed. Again, you know, I really don't know a lot about putting it myself but if you guys, you know, if anyone of you out there do Twitter, that's a type of thing that we'll say, "Hey, we posted a new links to an article, you know, check out – check out the web page."

Susan Emanuelle: OK, great. Thank you.

Operator: Your next question comes from the line of (David Cartwright). Your line is open.

(David Cartwright): Hello. I have three questions for you. The first question is if we receive a denial – a prepayment denial for one of these DRGs, will the physician who is involved with the case also be denied? How is that going to work?

Connie Leonard: At this time, the physician claim will not be denied, at least, through recover auditor review.

(David Cartwright): OK. Because there are some areas especially like, you know, Major Joint which is not on your list at this point in time where they have a huge role on that process or how the (inaudible) is in place and so on.

Connie Leonard: And I'm aware that when sometimes when the MACs view prepayment review, they do follow through to the physician claim but that is not something that we are doing at this time in the Recovery Audit prepayment review demonstration.

(David Cartwright): OK. The other question – the second question I have is I understand from Florida, some other DRGs that you don't have on your list – your MS-DRGs for review, there were DRGs like major joints, you know, cardiac pacemakers and (inaudible) and the fibulators and so on. Those are DRGs, I think, were

reviewed in prepayment fashion down in Florida. Are those – can we expect that those are coming as well it's just that they didn't make it to you list? And what's – and if so, what's kind of a general timeframe who do not know that?

Connie Leonard: Right now, as of this time, because we know that the MACs are reviewing a certain DRGs, they are not on our list for the Recovery Auditors to review. So what I do know that the list of DRGs on slide four (inaudible) the listed DRGs for the first six months of the program.

(David Cartwright): OK.

Connie Leonard: And after that, we will post additional MS-DRGs, you know, that we – that we're like for the next six months or so. So this list there – this nine or so (inaudible) that I listed on page four and wait for the six months of the demo and then we will release additional information possibly through another special event or forum or through the web site depending on what we feel would be the best forum.

(David Cartwright): OK. I think the last caller asked the question that was similar to what I have and that is will there be any kind of guidance or documentation like a local coverage determination memo that will indicate what it is you're looking for. And I'm thinking more in terms of the one that maybe coming down the pipe like major joints because again in Florida, they were pretty strict as I understand it and I wanted to see a lot of, you know, non-surgical intervention documented in the record before they would even authorized a total knee or something. And I guess, the question I have is for some of those DRGs that are more – I don't know how to describe this. But, you know, where there's more documentation requirements, will there be LCDs actually issued before you start the prepayment reviews?

Connie Leonard: I don't expect that there's going to be LCDs unless the MAC is already planning to implement a particular LCD for, you know, for their particular jurisdiction. So, any article or anything that we do post is going to be based on the national guidance in any manual or, you know, regulation or if there's an NCD, an NCD requirements. If there is an LCD, obviously, the Recovery Auditor will have to follow that LCD. But as of this time, I am not aware

they'll (inaudible) they say certainly could be in process of any particular LCDs in process for any of the particular MS-DRGs that we're looking at.

(David Cartwright): So the prepayment denials will have to base on national coverage determination levels?

Connie Leonard: If there's no local coverage determination in that particular state, then yes. Now if their MAC is in process, they'll already have an LCD in effect for one of this MS-DRGs then the RAC will have to follow that LCD for that particular space.

(David Cartwright): OK. All right. Well, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Dawn Croft). Your line is open.

(Dawn Croft): I'm sorry, my questions had been answered.

Operator: Your next question comes from Mary Kate Stinneford. Your line is open.

Mary Kate Stinneford: Hi, mine is sort of a question, sort of a comment. Because a lot of these short stay thing seem to (inaudible) whether or not the patient should have inpatient observation and it's a lot easier to make that determination after the spec. Does CMS given any thought to have a different payment schedule instead? Because in some of our RAC (inaudible) and say, "Oh well, they would have gotten the same treatment if they were in observation so we're not going to pay you for inpatient." But you can't turn around and pay the outpatient either. You have to do the ancillary. So that's one question.

My other question is are the DRG payments going to be recalculated since so many one day stays are being taken out of the equation for some of these? And my last question is, does CMS have any thoughts on doing precertification like insurance companies do which would give everybody a lot more certainty going forward?

Connie Leonard: Well, (inaudible) the first question, I do know that just recently in the outpatient perspective payment for some role for 2013, CMS did ask the

comments from the community about if the current inpatient policy. I don't have the current language with me but it's a (inaudible) opportunity for providers and associations in the industry to present, you know, their thoughts or their ideas on what CMS should do – I mean in the future from their inpatient policy. Because it is currently something that agency is looking at and it's something that, you know, all the way up to the administrator is very, very interested in.

As far as your second question, I really – I am not certainly I have almost zero knowledge as far as to recalculate DRG payments. So I do not know how they calculate those or if the denials that are occurring in these one day stays will impact future DRG payments. So I'm sorry, I don't know the answer to that question but because certainly if you send me a separate e-mail, then I could probably get you in touch with the right person that would. He might know that question.

And I'm sorry, answering those two questions I forgot your last question.

Mary Kate Stinneford: Oh, my last question was whether CMS has given any consideration to do pre-cert or preauthorization?

Connie Leonard: Oh, I'm sorry, you're right. You know, CMS was to do something like precertification or preauthorization, CMS actually needs that statutory authority. And it's not something that we currently have for all claim types. So, yes, I do know it is probably much easier for a hospital, you know, (inaudible) something that we don't have the authority to do these days.

Mary Kate Stinneford: OK, thanks.

Operator: Your next question comes from the line of (Lucy Igos). Your line is open.

(Lucy Igos): Hello.

Connie Leonard: Hello.

(Lucy Igos): Can you hear me?

Connie Leonard: Yes.

(Lucy Igos): Yes, I do have a couple of things I wanted to talk about. We'd screen the – I live in the state of Michigan and we also do not get a level one favorable letters either. So that was NGS and we're in the blackout period because we're switching from NGS to WPS. So and I was told by CGI who is our (inaudible) contractor that we were going to be in the black period until October 23, 2012. So I wonder whether you could check in to that and clarify that for us as well.

Connie Leonard: Certainly, we will clarify for the state of Michigan.

(Lucy Igos): OK. My next point is I know that this is going to start on August 27, 2012. I'm kind of wondering is it the ADR that you're going to send or you're going to give the names or the patients or the claims that are going to be on those ADRs? So those are the ones that we have billed and the hospital has billed and then you're going to take it from those, you know, you're going to look at the DRGs and then use that to place them on the ADR list for the medical records that you are requesting. Is that what you're talking about or is it just the ones how, you know, that's kind of a process that I don't think has been clarified?

Connie Leonard: Claims will be chosen based on the MS-DRG that's billed on a claim. And so this is some (inaudible) these claims for our prepayment review just based on the MS-DRGs that's in that particular claim. And we can set it but it does, you know, it's that number of claims or is that percentage or, you know, every nth claim or something like that. So it's going to be based on the MS-DRGs that's included in the claim. And the Recovery Auditor will get that claim information that was submitted and so they'll have the hit number and the patient name, et cetera.

(Lucy Igos): OK. The second, when the RAC has a no finding, will they also send a letter say no findings on those DRGs that were, you know, like the syncope one, you know, like if they have the findings, they will send a letter like they do normally.

Connie Leonard: Yes, they will.

(Lucy Igos): OK. Next, now the RAC statement of work says that they – I know you have said it several times that if we rebill or that we appeal for the Part A of these DRGs, like let's say, the syncope and we lose, you have said that we can only rebill for ancillary services. But the RAC statement of work says that they also can say that we can bill for a full Part B payment and that's why we continue to appeal some of these cases after it's been denied because we are, according to the RAC statement of work, we are eligible or according to their statement of work that hospitals have a right to get a full Part B payment. So I'm not sure why you keep saying that we can just rebill for ancillary services.

Connie Leonard: OK, RAC statement of work is a contractual document between the recover auditors and CMS. The Medicare policy is listed in the benefit payment policy manual and that's what dictates how CMS pays the claim. The statement of work has language in there regarding what contingency fees Recovery Auditors should receive if CMS changes policy or CMS systems as per allowed for the difference between the type of payment. But CMS payment policies are included on our manuals and our regulations but not in the Recovery Auditor's statement of work which is a contractual document between CMS and the RACs.

(Lucy Igos): So the statement of work is going to apply as well?

Connie Leonard: Statement of work applies to the Recovery Auditors and how the – what the Recovery Auditors responsibilities are and their contracts with CMS so that we provide the statement of work to providers just as a means of transparency and, you know, letting providers know what the responsibility is of the (inaudible) are to CMS but it is not – it should not be used as payment guidance. If the payment guidance and payment policy is directed by CMS in the CMS Manuals, the Benefit Policy Manual, the claim processing manual and then CMS regulations.

Operator: Your next question comes from the line of Stewart Presser. Your line is open.

Stewart Presser: Hi. Connie, just a couple of more issues. You had mentioned that if a provider is denied on a prepayment review by the RAC, they would only be able to submit a 12x claim for the approved ancillaries. National Government

Services, NGS, the MAC in J13 has issued guidance to hospitals that they would also be able to submit a 13x claim for any services that were provided prior to the audit to admit the patient. So in just about every syncope case, they're coming through the ED. So they've been worked up in the ED and then admitted. The ED visit fee plus any ancillaries in the ED would be billable on a 13x claim in addition to the inpatient ancillaries on a 12x claim.

Connie Leonard: (Inaudible) post-payment that article that – or the information that they posted, are they stating some CMS Manual or the Benefit Policy Manual as to, you know, allowing those prior visit days that come through?

Stewart Presser: I don't recall but…

Connie Leonard: OK.

Stewart Presser: …it is on their web site.

Connie Leonard: OK.

Stewart Presser: I can send you the article if you want.

Connie Leonard: Oh, that would be great, Stewart. I appreciate that. And we'll certainly, you know, (inaudible) – it is certainly – you know, we're not the rebilling experts but, you know, we certainly always help providers for the following Medicare Benefit Policy Manual as too far as what can be rebilled. And as far as, you know, hopefully that's what the MACs are doing but we certainly always come across configurations with some MACs that are doing something a little different. But…

Stewart Presser: It's important they vetted this was the central office before they post…

Connie Leonard: Right.

Stewart Presser: …the guidance.

Connie Leonard: Wonderful. And that would be great. And yes, please send that to me. We might be able to turn that into some kind of Q&A…

Stewart Presser: OK.

Connie Leonard: …for the prepayment so that everybody could see it.

Stewart Presser: OK. The last issue is with respect to appeals or for providers denied on a prepay review, there's no demand letter issued so they would be able to send their appeal into the MAC based on the entry on the remittance statements that this claim is now denied.

Connie Leonard: Correct, yes.

Stewart Presser: OK. All right, great. I'll send that article.

Connie Leonard: (Inaudible) yes.

Stewart Presser: OK, thanks.

Connie Leonard: Thanks, Stewart.

Stewart Presser: OK, take care.

Operator: Your next question comes from the line of (Margaret Sicell). Your line is open.

(Margaret Sicell): Hi, I just wanted to know about any criteria that might be posted for the DRGs that you have listed on the CMS note and obviously the ones that will be coming up. Will you be posting any type of criteria for what you expect to see from a medical necessity standpoint?

Connie Leonard: We will certainly post any links of any articles on any of these MS-DRGs that we already have released. And we can make sure that we get those up on the new web page that I was talking about, you know, next week. I'm not sure right here I hadn't went through and check exactly to see which one of these DRGs have been included in the provider compliance newsletter. But I will say I know what we have in the newsletters and you're not going to find specific criteria. You're going to find the examples and the links to the Medicare Benefit Policy Manual and the (inaudible) processes manual.

We will also ask the MAC and try to figure out if there's any links to particular articles and any – for particular (inaudible). We will try to gather all that we can to provide guidance to the providers for these particular DRGs as there – as (inaudible) under review. But I am not aware of as of right now of articles that have been completed by the MAC. But if there are some for particular (inaudible) even if there's this particular LCDs, we'll be sure we can get those links up there so people on those space can see them too.

(Margaret Sicell): OK. That would be pretty helpful for us and for educating our physicians. Thanks.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of Jill Zimmerman. Your line is open.

Jill Zimmerman: Is that for Jill Zimmerman?

Connie Leonard: Jill, I'm listening, go ahead.

Jill Zimmerman: Can you hear me?

Connie Leonard: Yes, go ahead.

Jill Zimmerman: I have a little question concerning the criteria that will be used for the medical necessity screening on the short stay claims. Is there any criteria that will be released to the facilities that we could use?

Connie Leonard: The basic criteria is going to – and we will certainly put links up to it but it's going to be the Medicare Benefit Policy Manual and what is in that. If we have any other particular articles on these MS-DRGs or if there are articles that have been released by MACs for a particular jurisdictions or LCDs, we'll make sure that we have links of those too. So we are going to go back and go through the provider compliance newsletters and see if any of these MS-DRGs have been discussed in the newsletters. So they're not going to have specific criteria but they're going to have examples and the links to the

Benefits Policy Manual. But primarily, it's going to be what's in the Medicare Benefit Policy Manual that inpatient (inaudible).

Jill Zimmerman: OK, so we're not – then that will not be based on the physician's medical decision making at the time that the patient is at our facility. This is going to be based on criteria on post discharge information.

Connie Leonard: The Medicare Benefit Policy Manual takes in consideration the physician judgment that they took into place when they made that decision to admit. And, you know, a lot of it comes down to the documentation that was in the record and what the physician documented. We will certainly make sure that we, you know, again add links to those manual requirements and what CMS uses when we're making this either pre- or post-payment medical necessity determination. And I will certainly take back because I certainly am caring from providers, you know, that you would like, you know, more a criteria for somebody as those particular MS-DRGs. And I will certainly take that back, you know, to my counterparts in the policy, you know, areas to see, you know, what additional type of information that we might be able to provide for some of these MS-DRGs.

Jill Zimmerman: OK, thank you. Because facilities, you know, their intent is to do it correctly from the beginning. So that would really help, thank you.

Connie Leonard: Absolutely. I do understand that. So that's a great suggestion. And we'll see here, maybe we can do a mini pilot or something inside the demo about providing additional of those criteria. So, you know, no guarantees but we'll see if we can, you know, do something. I certainly hear from you guys that you want a little bit more of criteria and specifics regarding this.

Operator: Your next question comes from the line of (Connie Wilson). Your line is open.

(Connie Wilson): Hello. My question is if we should expect the RAC to post those ADR issues on their web site just like they currently do for the post-payment request?

Connie Leonard: Yes. These will be posted to the Recovery Auditor's web site list of demonstration of prepay. But, again, they will also be posted on CMS' web

page but it's a little bit different because right now you do not see the post-payment issues on a CMS web page.

(Connie Wilson): OK. Then I'm talking about (inaudible), you know, case by case on their portal, we have…

Connie Leonard: I'm sorry. I'm sorry, I'm just confused. Yes, we are going to highly encouraged that the Recovery Auditors use the portal the same way prepay as they do for post-pay.

(Connie Wilson): OK, great. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Diana Chapman). Your line is open.

(Diana Chapman): In response to the last person, I would like to say that the RAC web site is not always correct on what is really going on with each denial. As a matter of fact, today, there were many, many errors on the RAC portal. So that needs to be cleaned up number one.

The second thing I would like to ask about is the appeals process begin with the receipt of the remittance advice, many RAC coordinators do not have access to the FISS System that is in the billers. So we will not receive a demand letter. Do you recommend that the RAC coordinators become proficient in the FISS System to find out when there's a denial? Currently, I can pull up a report on MAC prepayment denials based on denial code N109. If you do not have that denial code, I will not know anything about my appeal process or when to begin it.

Connie Leonard: On your first issue, is the RAC portal be incorrect. I don't know what state that you're in…

(Diana Chapman): Ohio.

Connie Leonard: …but if you – you're in Ohio. If you reach out to me just that you can either do it through the RAC e-mail or just through Connie.Leonard@cms.hhs.gov ,

then we will work with the RAC to make sure that their web site is up-to-date. And the (inaudible)…

(Diana Chapman): Can you repeat that, Connie.Leonard@?

Connie Leonard: cms.hhs.gov.

(Diana Chapman): OK.

Connie Leonard: And we will work with the RAC to make sure that there are – to see what's going on with our portal and why, you know, what happened and how some incorrect information got up there. The COR for region B is actually here in the room so she's hearing us and she will definitely followup with that. So I'd appreciate it if you could give us a little bit more information and I can forward it to her.

And definitely we are going – I will try to see what we can do to create a special reason code for these RAC prepayment reviews in the system. And certainly, you know, I certainly am not aware of how this access is granted to providers and how it works in each organization. But if it's possible for you or someone you work closely with to have that access or to get some type of reports from the billers because I certainly think that would be to your advantage given the sooner that you get these records in the sooner the (inaudible) get started and you guys can actually receive payment on a correct claim.

(Diana Chapman): Well, I received some information today from the billing office that to get an FISS account, it takes 90 days for a person to have an ID and a password. So is there anyone that I can check with to make this happen sooner?

Connie Leonard: If you would include that in your e-mail when you send it to me, I'll see what I can do working with that particular MAC. I can't guarantee anything but we'll see if we can get a request to be a little bit quicker.

(Diana Chapman): OK, thank you.

Connie Leonard: I just have to go the process that they had to go through. So, again, I will – and that I can't guarantee anything but we can always try.

(Diana Chapman): OK, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Amanda Bessing). Your line is open.

(Amanda Bessing): Hi, yes. When (inaudible) back off of another one – another lady that was speaking about the criteria. What is that benefit manual probably in the Medicare Benefit Policy?

Connie Leonard: The Medicare Benefit Policy Manual, yes. And we will make sure we put a link to it up on the web page. I don't know the chapters in the particular manual off the top of today but we can make sure we can put the links up there for you.

(Amanda Bessing): OK. Because I was just kind of wondering, are you looking at a certain dollars threshold like if it's going to pay or billed over like $50,000 or certain methods of payments as well. So that's kind of the criteria that I was wondering…

Connie Leonard: I got you (inaudible). So you're coming at this from the criteria of what claims we're going to choose for review?

(Amanda Bessing): Yes, like in addition to that DRG, what other criteria would be?

Connie Leonard: (Inaudible), sorry. Yes. And we are, you know, at least, again, right now in the beginning is just going to be based off of the MS-DRG but I do expect that we will get more sophisticated in choosing claims for review. And that certainly down the road we may limit it to (inaudible) claims over a certain dollar threshold but certainly maybe one of the criteria. In the beginning, though, it is just going to be, you know, claims for this particular MS-DRG, you know, MS-DRG 312. And we will hopefully get more sophisticated.

And as we get more sophisticated, hopefully it will be less burden on providers (inaudible).

(Amanda Bessing): And will that be – will that criteria be included when you will do get more sophisticated?

Connie Leonard: We will certainly be able to share some of the criteria with the provider community so maybe probably not all of it. But as we get more sophisticated and are able to tailor it down, we will certainly share a piece or pieces with the community, yes.

(Amanda Bessing): All right, thank you. And then my other question is in regards to par and non-par appeals/disputes. Specifically with non-par, will they follow your same process or they to go to a different place for resolution?

Connie Leonard: That's a great question and I actually don't know the answer. But we'll make sure we get it up on the web site. Thank you.

(Amanda Bessing): All right, thank you. And also like – this is kind of like two-part for appeals and disputes.

Connie Leonard: OK, (inaudible). OK.

(Amanda Bessing): Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Michael Ross). Your line is open.

(Michael Ross): Oh, yes. Will all prepay reviews in the demonstration be complex reviews or do you anticipate any automated or semi-automated reviews during the demonstration?

Connie Leonard: It will all be complex.

(Michael Ross): Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of Cindy Mathis. Your line is open.

Cindy Mathis: My questions have been answered, thank you.

Operator: Again, ladies and gentlemen, if you would like to ask a question, please press star one. And if you'd like to remove your question from the queue, please press the pound key.

Your next question comes from the line of (Linda English). Your line is open.

(Linda English): Hi. On your slide, we talked about the MS-DRGs that are being reviewed. Once you start to space in the other DRGs, are the first ones then eliminated or is it combined list of reviews?

Connie Leonard: It will be a combine list of reviews.

(Linda English): OK, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Michelle Gifford). Your line is open.

(Michelle Gifford): Hi, I have several questions. Are there any provisions for providers who because of, you know – there's a number of prepayment reviews and (inaudible) the payments or undergoing financial hardship, is there anything that you can do?

Connie Leonard: Certainly. (Inaudible), you know, if you're having hardships just pulling all the records together from a post-payment side, certainly contact the particular RAC (inaudible) and get an extension on those post-pay side. If you say financial hardship perspective, you know – and the same thing goes which is probably best to contact the MAC and potentially the Recovery Auditor to see if there's any type of temporary relief from the prepayment review perspective. We certainly always can, you know, contact CMS to see if there's anything that can potentially be done on a temporary basis, you know, while you're getting better and able to handle, you know, the amount of reviews that's been coming at you.

(Michelle Gifford): OK. As far as who is included in the demonstration, is it – it doesn't include all hospitals including IPPS excluded providers?

Connie Leonard: It (inaudible) any particular facility that might submit a claim for these particular MS-DRGs for, again, a short stay, two days or less.

(Michelle Gifford): OK.

OK. My…

Connie Leonard: Thank you.

(Michelle Gifford): …last question…

Connie Leonard: Oh, I'm sorry.

(Michelle Gifford): Is there – besides – I know that if you – the sooner you submit your records, the sooner they'll get reviewed.

Connie Leonard: Right.

(Michelle Gifford): Is there any other means to expedite review and minimize the delay in payment?

Connie Leonard: That really is the only one that at least that I can think of right now would be is the faster you get records in, the faster that 45 days happens from the perspective of the Recovery Auditor doing that type of prepayment review.

And, again, I don't expect that a particular provider is going to have 100 percent of any of these particular DRGs (inaudible) a prepayment review so that there will still be some cash flow, you know, coming through to the provider. Now, obviously, that doesn't – if a single provider could be undergoing 100 percent prepayment review by another entity and if that certainly the case, again, you reach out to the Recovery Auditor to let them know and they can certainly let us know and we can see if there's anything we can do at least – and maybe at least of the Recovery Auditor (inaudible) temporarily.

(Michelle Gifford): OK, that was it. Thank you very much.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Jeneth Mill). Your line is open.

(Jeneth Mill): Yes, I have a question about the 45-day time period as far as receiving the denial. If they passed the 45 days and then the account is paid, then it's ineligible to be reviewed in the post-payment review process for the RACs?

Connie Leonard: No, it's not.

(Jeneth Mill): So it's (inaudible) to get that point if they missed their timeframe.

Connie Leonard: Correct.

(Jeneth Mill): And if we're having problems with that, who do we need to contact?

Connie Leonard: The appropriate CMS representative for each region. We do have them listed on the RAC web page which is just www.cms.gov/RAC . And we have a particular CMS point of contacts for region A, B, C & D. And if you would contact them, we certainly would want to know.

(Jeneth Mill): OK, thank you very much.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Vicki Ement). Your line is open.

(Vicki Ement): Hi, our hospital – we're up in Anchorage, Alaska. And we actually are an (inaudible) facility. And so we have trailblazers. And we're all considered part of Texas for our post-payment RAC. So now, I know that we're changing, we're going to transition to (Novota) this fall. But I know that Texas is part of the demonstration project so does that – will we be included on that demonstration project?

Connie Leonard: No, you're not.

(Vicki Ement): We will not.

Connie Leonard: You will not. No. Because you're physically located in Alaska, correct?

(Vicki Ement): Correct.

Connie Leonard: No, then you will not be included.

(Vicki Ement): OK. So this is list where the hospitals are physically located?

Connie Leonard: Yes.

(Vicki Ement): OK, thank you so much.

Connie Leonard: Thank you for that distinction.

Operator: Your next question comes from the line of (Dr. Steve Myerson). Your line is open.

(Dr. Steve Myerson): Yes, very good. Thank you. I actually have three questions. One is I noticed that the slides go and the presentation says that the ADR request would come from the MAC and the prepayment review is being done by the RAC. So I'm just wondering why have that complicated extra step? And can hospitals be assured that the records that they send to the MAC are going to be transferred to the RAC for review and what is the process?

My second question if I can go through them is, I'm just wondering as a general question, why CMS (inaudible) that they're needed to start a whole new prepayment program with the RAC when the MACs are already doing prepayment, why create a whole new complicated process? When it seems like it would have been simpler to just direct the RAC – oh, I'm sorry the MACs to start reviewing certain DRGs that they're now assigning to the RACs?

And my third question concerns appeals. You said if a hospital meets the 30-day deadline for supplying records that they would appeal through the routine work appeal process so there wouldn't be any basis for the denial except (inaudible) to send records. And that appeal would be done by the MAC. So

does that mean that the MAC would then be starting a whole new complex medical review on that record? And how would the hospital phrase its appeal letter except to say we didn't send the records before, sorry, here they are? So if you like, I can go back over those for those three questions please.

Connie Leonard: As a followup – I'll start with the last one. I just had the question on my head and (inaudible) for a second. But you're right. The way the process works right now is that if a provider does know the documentation, it goes for even on a post-pay side. You know, the MAC is the one that hears that appeal. And if that's the case have no documentation, they are basically starting from scratch and making an initial decision on that claim. So it would be the same process in the prepayment demonstration. Right now, we certainly do not – we do not have it in our process that, you know, this gets back to the MAC to answer them.

First your second question about to why CMS, you know, I was going to down this road. You know, I really can sense you. CMS, you know, believes that prepayment review when no provider wants to be audited, it at least provides them for immediate feedback to providers then there isn't a delay and waiting two to three years for that claim to be audited, you know, by another entity. And, you know, (inaudible), it's probably some, you know, alongside simpler just to have the MAC (inaudible) or more targeted review on these particular DRGs. But, you know, CMS is limited by the amount of funding we get for medical review and so, you know, one way to conduct additional review, you know, that's a different funding stream is used, you know, Recovery Audit Contractor Program. And so that's why we are, you know, joined this demonstration to see if this additional review is going to (inaudible). And, again, hopefully get to the point, you know, where, you know – what policies need to be clarified, what education needs to occur so that we can pay that claim right the first time.

And I will say, you know, when we devised the process, you know, we were under the belief that the request from the MAC for the additional documentation was going to be electronic. And that was why we have the request coming from the MAC and not the Recovery Auditor because we wanted the provider to get that instantaneously to not have to wait for the mail

time to get that additional documentation request. So, again, I'm hearing today that they might not be true, that there may be some MACs who actually still – maybe they're doing it both, do the DDEs with (inaudible) papers. (Inaudible) follow-up a little bit more on that but the original promise was the MAC would send out the – would send the ADR request electronically to get that provider, you know, more time to get that record to the RAC. And then the address on that request will actually be the Recovery Auditor's address that the provider will send the record right to the RAC.

(Dr. Steve Myerson): And so the records will be sent directly to the RAC, not to the MAC?

Connie Leonard: Right. You want to send them to the RAC, or the Recovery Auditor. And that way – while the request is going to come from the MAC, you want to send the record to the Recovery Auditor. And that address should be on the request.

(Dr. Steve Myerson): OK.

OK, thank you.

Connie Leonard: Now, if a provider messes up and accidentally (inaudible) it to the MAC, the MAC will pull her but you're right, that adds another layer that we don't really need.

(Dr. Steve Myerson): Thank you.

Connie Leonard: Thank you.

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

(Nicole Smith): Hi. I was wondering, will providers be able to submit this documentation electronically through the ESMD program?

Connie Leonard: Yes. If you were participating in the ESMD program, then all of the RACs, all of the Recovery Auditors do participate in that program and they will be able to set the information.

(Nicole Smith): OK, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Ellen Scott). Your line is open.

(Ellen Scott): Yes, thank you very much. I was just interested if a hospital do this to appeal a denial. And it goes through the various appeal levels via through the ALJ level, the hospital may miss the opportunity to rebill. Is there any provisions for that?

Connie Leonard: My understanding is that currently – you're right. The ability to rebill does timely filing does come into play. So, you know, I don't – to the best of my knowledge, it will still come into play from (inaudible) perspective. There's no qualification from an appeal perspective.

Connie Leonard: (Inaudible). Go ahead.

(Ellen Scott): Oh, I'm sorry. Also, it's kind of punitive to the hospitals because, again, if a claim is denied and then goes to the appeal process which may take a significantly long amount of time. There doesn't seem to be a provision for interest payments on this claims that essentially were clean claims initially.

Connie Leonard: From a prepayment perspective, I do believe that that is correct. That this is – it's get denied even at higher levels of (inaudible). I am not aware of any interest payment provisions like there is from a post-payment perspective. I think that's a correct statement.

(Ellen Scott): OK, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Jessica Prince). Your line is open. Again, (Jessica Prince) your line is open.

(Jessica Prince): My questions had been answered, thank you.

Operator: Your next question comes from (Kate Thomas). Your line is open.

(Kate Thomas): I just – I think it may have been answered or you may have said that you weren't sure but my question is (inaudible) establish with this demonstration project a percent threshold of errors above or below which you would continue to review the hospital or not as this case with other focus reviews.

Connie Leonard: In the beginning, we are not going to be focused on the providers as much as we are on the MS-DRG but I certainly expect that we will move in a direction of only reviewing providers that have, you know, high error rate in these particular MS-DRGs. But in the beginning, it's just going to be the MS-DRG, it's not going to be provider specific.

(Kate Thomas): OK. But if you say high error rate, what percentage would that be?

Connie Leonard: At this time, I don't know what the percentage would be but if we were moving towards that, we'll certainly share as much information with the provider community that we were able to.

(Kate Thomas): All right, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Dale Gibson). Your line is open.

(Dale Gibson): Yes, I want to discuss a quick answer that occurred recently with the MAC who was doing a prepayment review. I had a very large claim and it went to prepayment review. It was a quarter of million dollar claim went into prepayment review – went to the review process and was approved. During that process, a patient went into another hospital for short stay. The patient was into life time reserve day. Those days were used up on the second smaller admission. The patient now claims are denied because of lack of days even thought the claim went in in proper sequence and was a clean claim. The patient is now looking at a quarter of a million dollar that the patient is expected to pay. Have you all thought about that process on making sure the claims are paid in sequence if they're claimed?

Connie Leonard: You know, that's a very interesting – and I am surprise that they're not paying by sequence. If you would send that, you know, just – you know, a if you

have to write up, you don't have to give in the claim information, I can certainly pass that on to the claim staff and more the prepayment staff to see how it's suppose to work. Because…

(Dale Gibson): I talked about…

Connie Leonard: …you're right definitely it's a big liability for the beneficiary.

(Dale Gibson): I talked to the MAC and they said there is no way that they can pay those claims in sequence. I mean, you know, the second admission – I don't think it's this instance but the second admission could even go into a different MAC.

Connie Leonard: Oh, yes, you're right about that.

(Dale Gibson): I mean, this patient is now looking at a quarter of a million dollars that the patient owes.

Connie Leonard: No. That's really a great point that we will certainly back to present to the policy staff around here. Because – but clearly, it's not the (inaudible) the consequence of prepayment review. Well, thank you for that – thank you for bringing that up. That's up a very great point.

Operator: Your next question comes from the line of (Donna Igo). Your line is open.

(Donna Igo): Yes, hello. I'm calling, I have a few questions on the request. We're currently receiving the request for records to be sent for a review to the (Safeguard). Should we be receiving those since the requests aren't starting until August 25th?

Connie Leonard: (Safeguard) is typically not a – (Safeguard) is actually not a Recovery Auditor. They're one of our (inaudible) contractor. So that is – it's definitely different that there are another contractor doing medical review but it's not part of the prepayment demonstration.

(Donna Igo): Oh, OK. All right, so you wouldn't know any information regarding that?

Connie Leonard: I don't, no.

(Donna Igo): OK. All right. That's the only question I had. Thank you.

Connie Leonard: OK, thank you.

Male: Connie, I believe we're at the end of call time here. I have 4:02. Do you want to offer closing remarks or do you want to keep going?

Connie Leonard: Well, I certainly will say that if anyone has additional questions that didn't get out today, they're certainly on page seven of the slide. There is an e-mail address. It's RAC@cms.hhs.gov . Feel free to send any questions into that mailbox as well as we will post some frequently asked questions or some of the questions that we did not have 100 percent answers to today on our web site, within the next week, and look at those questions we have answer so it'll kind be a flow of issues. So, you know, for the next week or so you might want to check the web page on a regular basis.

Other than that, just send any additional questions to the mailbox then we'll try to get them answered as soon as we can.

And thanks everybody.

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

END