June 5, 2012

Cahaba Government Benefit Administrators®, LLC

Presents

J10 Hospital Association Meeting

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Disclaimer

This resource is not a legal document. This presentation was prepared as a tool to assist our providers. This presentation was current at the time it was created.

Although every reasonable effort has been made to assure accurate information, responsibility for correct claims submission lies with the provider of services.

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Part 1: Topics

- Association Process Reminder
- Medicare Appeals
- Part A Adjustments/Clerical Error Reopening
- Provider Enrollment Revalidation
- Top Telephone Inquiries
- Cahaba Self Service Tools

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Association Process Reminder

Call Provider Contact Center (PCC)

Obtain Reference Number

No Level 2 follow up within 10 business days

Contact Association Point of Contact (POC)

Issue forwarded to Cahaba's Provider Relation Research Specialist (PRRS)

PRRS works with provider to resolve issue

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Next Meeting

MARK YOUR CALENDARS!

What: J10 Hospital Association Meeting

When: November 7, 2012

Where: Piedmont Hospital
Atlanta, Georgia

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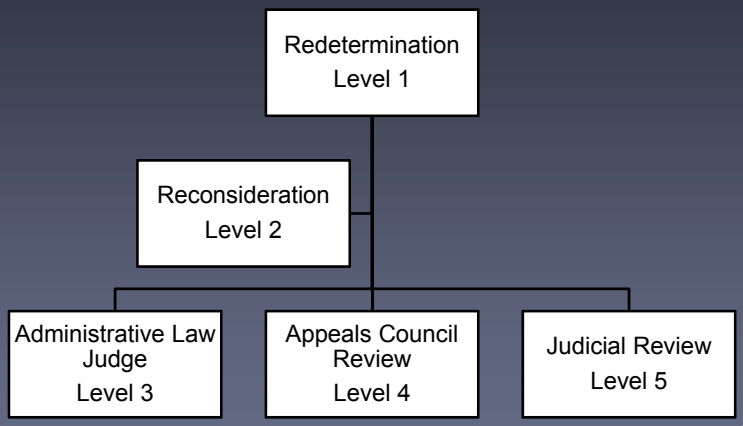
Levels of the Appeals Process



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Appeal Reminders

- Complete the Part A Redetermination form completely and accurately
  - Include correct Document Control Number (DCN)
  - Handwritten signature required
  - Follow Appeals process timely filing guidelines
    - Appeals calculator at https://www.cahabagba.com/part_a/appeals/calc.htm
- Additional Development Request (ADR) process should be completed prior to submitting an appeal, if applicable

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Additional Development Request

- Direct Data Entry (DDE) users
  - Obtain ADR letters electronically
- Advantages to receiving ADRs
  - Improves timeliness
  - Cost effective
  - Quicker response
- Cahaba strives to align its goals with CMS and become paperless

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Reconsideration Address Change

- Recent address change to submit Reconsideration requests

QIC Part A East Appeals
Maximus Federal Services
3760 Monroe Avenue
Suite 701
Pittsford, NY 14534-1302

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CER/Hardcopy Adjustments

- Clerical Error Reopening = CER
- Part A CER does not handle requests via phone.
- CER handles
  - Requests on the claim that needs correction or additions; DDE users should correct online
  - Claims with medical denials but providers are making a change to non-medically denied line item
- Complete CER form on the Cahaba GBA website

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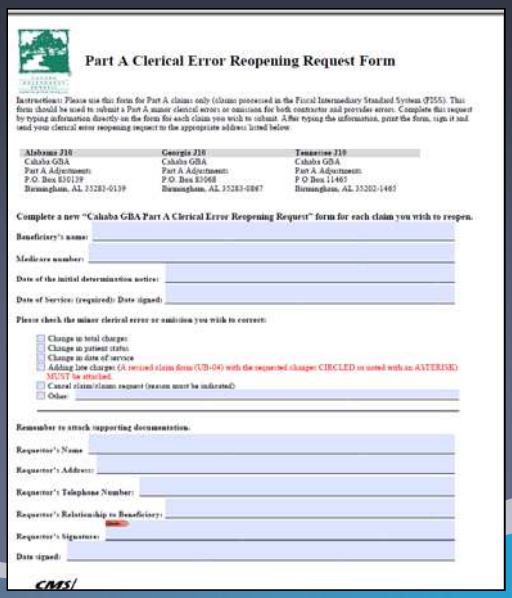
https://www.cahabagba.com/part_a/forms/PartACERRequestForm.pdf



Part A Clerical Error Reopening Request Form

Instructions: Please use this form for Part A claims only (claims processed in the Fiscal Intermediary Standard System (FISS). This form should be used to submit a Part A minor clerical errors or omission for both contractor and provider errors. Complete this request by typing information directly on the form for each claim you wish to submit. After typing the information, print the form, sign it and send your clerical error reopening request to the appropriate address listed below.

Alabama J10	Georgia J10	Tennessee J10
Cahaba GBA Part A Adjustment P.O. Box 830139 Birmingham, AL 35283-0139	Cahaba GBA Part A Adjustment P.O. Box 83568 Birmingham, AL 35283-0867	Cahaba GBA Part A Adjustment P O Box 11465 Birmingham, AL 35202-1465

Complete a new "Cahaba GBA Part A Clerical Error Reopening Request" form for each claim you wish to reopen.

Beneficiary's name:

Medicare number:

Date of the initial determination notice:

Date of Service: (required): Date signed:

Please check the minor clerical error or omission you wish to correct:

- Change in total charge:
- Change in patient status
- Change in date of service
- Adding line charge: (A revised claim form (UB-04) with the requested changes CIRCLED or noted with an ASTERISK) MUST be attached.
- Cancel claim/claim request (reason must be indicated)
- Other:

Remember to attach supporting documentation.

Requestor's Name

Requestor's Address:

Requestor's Telephone Number:

Requestor's Relationship to Beneficiary:

Requestor's Signature:

Date signed:

CMS/

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Medicare Retroactive Entitlement

- Effective August 27, 2012
- Change Request 7834 modifies the timely filing exceptions on Retroactive Medicare entitlement.
- Medicare contractors shall check the Common Working File (CWF) to verify retroactive entitlement, if official Social Security letter is not submitted

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Medicare Retroactive Entitlement

- These requests will be handled by Cahaba GBA's Part A Clerical Error Reopening/Adjustments department.
- Mail claims to the address for your specific state:

Alabama	Georgia	Tennessee
Cahaba GBA Attention: Part A Adjustments/Re-openings P.O. Box 830139 Birmingham, AL 35283-0139	Cahaba GBA Attention: Part A Adjustments/Re-openings P.O. Box 830139 Birmingham, AL 35283-0139	Cahaba GBA Attention: Part A Adjustments/Re-openings P.O. Box 830139 Birmingham, AL 35283-0139

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Provider Enrollment Revalidation Webpage

https://www.cahabagba.com/part_a/enroll_update_your_records/enroll_revalidation.htm

Were you sent a Revalidation request?

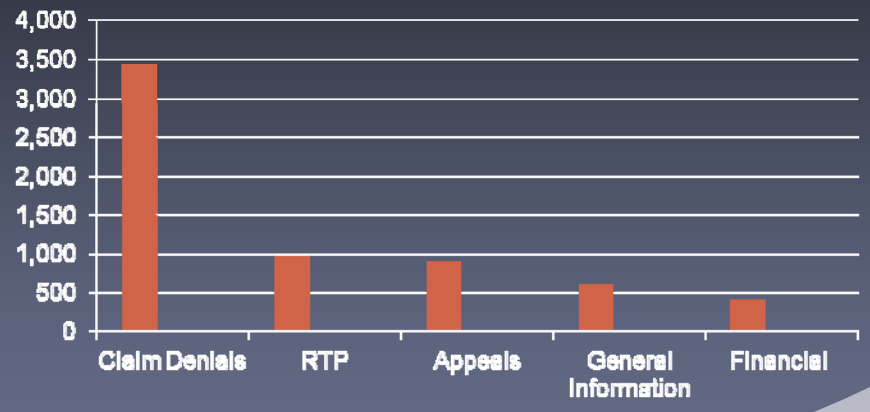
- Verify if your provider has received a revalidation letter.
- CMS has updated the information on www.cms.gov

Downloads

Contact Information for Medicare Enrollment Contractors [PDF, 283KB]
Sample A/B Revalidation Letter [PDF, 95KB]
Sample DMEPOS (NSC) Revalidation Letter [PDF, 29KB]
Medicare Part A/B Revalidations Mailed September - October 2011 [ZIP, 3MB]
Medicare Part A/B Revalidations Mailed November - December 2011 [ZIP, 617KB]
Medicare Part A/B Revalidations Mailed January 2012 [ZIP, 8KB]
Medicare Part A/B Revalidations Mailed February - March 2012 [ZIP, 456KB]
NSC Revalidation Letters Mailed [ZIP, 296KB]
National Provider Call Transcript - October 27, 2011 [PDF, 125KB]
MLN Article SE1126: Further Details on the Revalidation of Provider Enrollment Information [PDF, 91KB]
MLN Article SE1130: Implementation of Pay.gov Application Fee Collection Process through PECOS [PDF, 90KB]
MLN Article MM7350: Implementation of Provider Enrollment Provisions in CMS-6028-FC [PDF, 97KB]

Top Telephone Inquiries

May 2012



RTP = Return to Provider

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Learning Management System

Cahaba Website Redesign

Part A Calendar of Events

https://www.cahabagba.com/apps/course_registration/al/calendar.jsp

Webinar
- **Cahaba Website Redesign**
- June 19, 2012
- 1PM – 2 PM CST

Webinar
- **Direct Data Entry 1: Eligibility and Inquiries**
- July 10, 2012
- 1PM – 2:30 PM CST

Webinar
- **Direct Data Entry 2: Claim Adjustments and Attachments**
- July 17, 2012
- 1PM – 2:30 PM CST

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PART 2: CMS UPDATES

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Part 2: Topics

- Provider Enrollment Applications
- Electronic Funds Transfer (EFT)
- Change Requests
  - CR 7260
  - CR 7762
  - CR 7792
  - CR 7794
- Electronic Health Records (EHR)
- HIPAA 5010

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Medicare Enrollment Applications

- Applications can now be submitted 30 days sooner
- Paper submissions and PECOS applications may be submitted 60 days prior to the effective date
- Excluded:
  - Ambulatory Surgery Centers (ASCs)
  - Portable X-ray Suppliers (PXRs)
  - Change of Ownership (CHOW)

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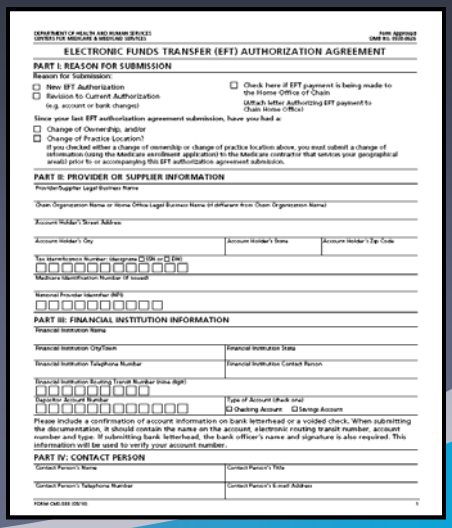
Electronic Funds Transfer (EFT)

- CMS mandates federal payments to providers and suppliers only by electronic means
- EFT required:
  - At the time of enrollment
  - Enrollment change request
  - Upon revalidation



ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ New EFT Authorization
☐ Revision to Current Authorization
(e.g. account or bank changes)
☐ Check here if EFT payment is being made to the Home Office of Chain
(Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

☐ Change of Ownership, and/or
☐ Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder's Street Address

Account Holder's City | Account Holder's State | Account Holder's Zip Code

Tax Identification Number (designate ☐ SSN or ☐ EIN)

Medicare Identification Number (if known)

National Provider Identifier (NPI)

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution City/Town | Financial Institution State

Financial Institution Telephone Number | Financial Institution Contact Person

Financial Institution Routing Transit Number (nine digit)

Depositor Account Number | Type of Account (check one) ☐ Checking Account ☐ Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

PART IV: CONTACT PERSON

Contact Person's Name | Contact Person's Title

Contact Person's Telephone Number | Contact Person's E-mail Address

FORM CMS-588 (05/10) 1

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PECOS Enhancements

- Major improvements implemented
  - Incorporate search capabilities on the My Enrollments page
  - Increase access to information
  - Allow electronic signature of Certification Statement and Electronic Funds Transfer Agreement

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Change Request (CR) 7260

- CWF Name and HIC Number mismatch
- Part A claims rejected for this reason will return to provider (RTP)
- Remittance advice will show remark codes:
  - MA130
  - MA61
- Only originally submitted information regarding the beneficiary will be returned to provider

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Change Request (CR) 7762

- New billing policy for hospital dialysis
- Effective for services on or after October 1, 2012
- HCPCS code G0257 should only be reported for:
  - TOB 13X (hospital outpatient)
  - TOB 85X (Critical Access Hospital)
- Reason code M20
  - Missing/Incomplete/Invalid HCPCS

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Change Request (CR) 7792

- Announces new occurrence code
  - Occurrence code 55
  - Used to report date-of-death
- Effective October 1, 2012

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7792.pdf

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Change Request (CR) 7794

- Effective July 1, 2012
- Influenza virus vaccine code Q2034
- Part B deductible and coinsurance do not APPLY
- For July 1 – September 30, 2012 dates of service:
  - Local pricing guidelines used
- After September 30, 2012
  - Medicare Part B payment limit used

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Electronic Health Records (EHR)

- An Electronic Health Record (EHR) is an electronic version of a patient's medical history including:
  - Demographics
  - Progress notes
  - Problems
  - Medications
  - Past medical history
  - Laboratory data and radiology reports

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Medicare EHR Incentive Program

- The following information is now available on the CMS website for those eligible facilities who have demonstrated meaningful use:
  - Names
  - Business Phone Numbers
  - Business addresses
  - Information will be updated quarterly
- For more information visit:
  http://www.cms.gov/Regulations-and Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/15_Eligibility.asp

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Version 5010 Facts

- Extension of discretion period through June 30, 2012
- All 4010 transactions received after June 29th (3:30 PM CT) will be rejected
- 4010 submitters will receive a rejected file transaction (997 with code "R")
- Cahaba 4010 Submitter's daily log will be updated with reminder that 4010 transactions are no longer supported

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Avoid 5010 Claim Rejections

- Zip code
  - Use a complete 9-digit ZIP for billing provider and service facility location
- Billing provider address
  - Use a physical address for billing provider
  - PO Box can be used for payments and correspondence
- National Provider Identifier (NPI)
  - Only the NPI is allowed as the primary identifier
  - Tax ID and Social Security Number no longer allowed

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PART 3: CLINICAL EDUCATION

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Part 3: Topics

- Comprehensive Error Rate Testing Program
- Medical Record Reviews and Errors
- CMS Signature Requirements
- Resources

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Comprehensive Error Rate Testing Program

http://www.cms.gov/cert/

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The CERT Review Process

- Claims selected for review.
- CERT Documentation Contractor requests medical records.
- CERT Review Contractor review the medical records.
- Error rates are calculated and reported.
- Provider file appeals to Cahaba GBA.

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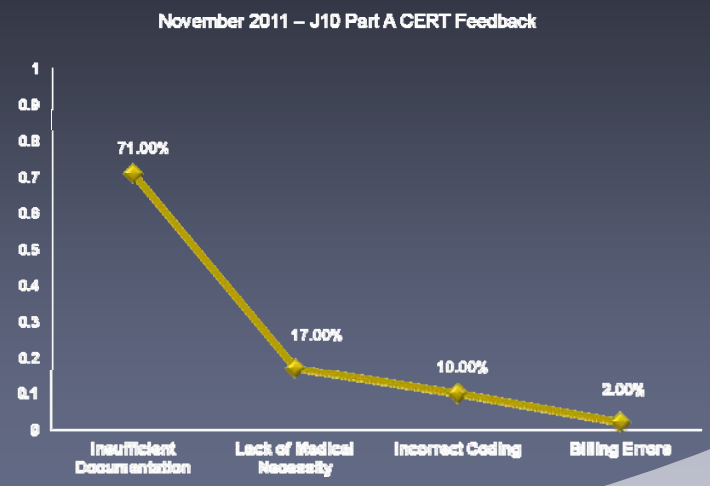
CERT Feedback Categories



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CERT Special Project

- Prepayment Review DRG's identified for special project:
- Reviews focus on medical necessity for acute inpatient hospitalization.
  - DRG 247 - Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without MCC
  - DRG 313 - Chest Pain
  - DRG 392 - Esophagitis, Gastroenteritis and miscellaneous Digestive Disorders w/o MCC
  - DRG 552 - Medical Back Problems w/o MCC

CERT Special Project Targeted Review Results article:
https://www.cahabagba.com/part_a/whats_new/20120124_cert_results.htm

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MEDICAL REVIEW

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Inpatient Rehabilitation

- Denials for TOB 11X:
  - CMG A0801-A0806 - Replacement of Lower Extremity Joint
  - CMG A2001-A2004 - Debility
- Medical Record Review:
  - Documentation did not meet technical requirements.
  - Admission did not appear reasonable and necessary.

Medicare Part A Resources - What's New section to view Widespread Targeted Review Results: https://www.cahabagba.com/part_a/index.htm

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Outpatient Rehabilitation

- Denials for TOB 74X and 11X:
  - Lack of sufficient medical justification (Denial Reason 54155)
  - Documentation did not support appropriate certification or recertification (Denial Reason 53714)
  - Billed services not validated in medical records (Denial Reason 53603)
  - Lack of documentation, services not reasonable and necessary (Denial Reason 55520)
  - Non-covered supplies or services (Denial Reason 55511)

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Ambulance

- Denials for TOB 13X A4028 (non-emergent)
  - Lack of physician certification for ambulance transport.
  - Certification for ambulance transport was not signed by the physician.
  - Ambulance transport was not medically necessary based on documentation submitted.
  - The documentation submitted does not indicate that the patient's condition is such that use of any other method of transportation was contraindicated.
  - Transportation from one appropriate facility to another appropriate facility is not covered by Medicare.
  - Documentation to validate ambulance transport was not submitted.

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Serum B Natriuretic Peptide

- TOB 14X - Outpatient hospital billing of B-type Natriuretic Peptide (BNP)
  - HCPCS 83880
- Reasonable and necessary for the following:
  - Establishing CHF diagnosis in acutely ill patients presenting with dyspnea, or;
  - Predicting the long term risk of cardiac events or death when measured in the first few days after and acute coronary event.
- Documentation needs to support medical urgency:
  - LCD guidelines (L30046).
  - BNP should not be performed as a "routine" test.
  - Submit correct ICD9 and HCPCS codes.
- Submit documentation timely.

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Current Errors

- CERT and Medical Review
  - Medical Necessity
  - Signatures
  - Lab orders
  - Therapy Services

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Avoiding Errors

- Submit complete records; conduct self audits
- Authenticate medical records; signatures
- Review CPT/HCPCS codes
- Educate physicians
- Document/Document/Document
- Utilize best practice
- Submit records timely
- Implement corrective action plans
- Appeals

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Signature Requirements

Change Request 6698:
Signature Requirements for Medical Review Purposes

- For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author.
  - Hand written or Electronic signature
- Stamp signatures are not acceptable.

Program Integrity Manual 100 – 8: Chapter 3, Section 3.4.1.1 B
Transmittal 327: Change Request 6698

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Electronic Medical Records

CMS - Electronic Submission of Medical Records (esMD)
- Cahaba GBA can accept esMD
- esMD is optional

- Phase 1
  - EsMD live date - September 15, 2011
  - Providers still receive paper mail record request
  - Option to submit electronically (esMD)
- Phase 2 – future
  - Providers receive electronic documentation requests
  - Option to submit electronically (esMD)

CMS esMD video available on Electronic Submission of Medical Records (esMD) webpage.

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Swing Bed Services

- Swing Bed Services Fact Sheet
  - MLN number ICN 006951
- Requirements apply to:
  - Hospitals
  - Critical Access Hospitals
  - Swing bed services payments
- Medicare Learning Network – Swing Bed Services:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SwingBedFactsheet.pdf

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CMS Billing Education

- Medicare Part A Billing Certificate Program:
  - Learn about the Medicare Program
  - Special focus on Medicare billing
  - Self-paced course
  - Specifics for your provider type
- Certificate Requirements:
  - Successfully complete all required web-based training courses;
  - Complete all required readings, and;
  - Achieve 75 % or higher score on post-assessment.

Medicare Billing Certificate Program for Part A Providers, click on Web-Based Training Modules at: http://www.CMS.gov/MLNproducts

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CMS Resources

- CMS CERT website: https://www.cms.gov/cert/
- Cahaba GBA CERT web page: https://www.cahabagba.com/part_a/education_and_outreach/cert/index.htm
- Medlearn Matters (MLN) Fact Sheet - Signature Requirements: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf
- CMS - Electronic Submission of Medical Records (esMD): https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/index.html
- Transportation Services: Ambulance LCD - (DL30022): https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm

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Now a 10 minute break

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PART 4: PROVIDER AUDIT AND REIMBURSEMENT UPDATES

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Part 4: Topics

- Demand Letter Updates
- Remittance Advice Updates
- Immediate Recoupments
- CMS Resources

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Demand Letter Updates

- ***October 29, 2011**, CMS issued a mandatory direction to eliminate 2nd Demand Letters*
- ***January 3, 2012**, CMS issued **CR 7436,** which directed that the responsibility for mailing Demand letters shift to the MAC*

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Demand Letter Updates (cont.)

- The demand letters are generated based on an **automated system** setup by CMS

The automated system generates letters to the physical address of your facility which was obtained from your provider enrollment data

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Demand Letter Address Updates

The address for the demand letters is defined as:

- "Practice Location Information" in Section 4A on your Provider/Supplier Enrollment application, CMS Form-855A
- Providers may choose to update their address information via CMS Form-855A to include a specific contact at your facility. This could be done by including an "Attn." line so the correspondence can be directed to a specific individual

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Demand Letter Address Updates

- **Note: This change would impact other demand letter correspondences (non-RAC) that are also generated from the "Practice Location Information"**

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Demand Letter Updates (cont.)

- **Under Tolerance (CR2292):**
  - The automated system does not generate demand letters for 935 (RAC) ARs less than $25.
  - ARs are aggregated until a total of $25 is reached
  - Once the aggregated total of $25 is reached a demand letter is generated to include each individual AR.

Note: No penalty is assessed until a demand letter is sent and the clock begins ticking.

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Remittance Advice Updates

Reporting of recoupment for overpayment on the Remittance Advice (RA) (CR7499):

- CMS implemented the CR 7499, **April 2, 2012**. This changed the remittance reporting by providing the Patient Control Number rather than the HIC number *(Medicare Health Insurance Claim Number)*

Note: Please make sure that your remittance vendor is aware of this change

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Remittance Advice Updates (cont.)

Reporting of recoupment for overpayment on the Remittance Advice (RA) CR6870:

- In an effort to enable providers to reconcile records and payments easier, CMS implemented CR6870, July 5, 2011. CR6870 instructed that multiple PLB lines appear on the remits, however, this process did not work as CMS directed
- Oct 20, 2011, CMS put a corrected change of action into place. The new process allows providers to reconcile their remits easier by listing all of the adjustment information in one location

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Immediate Recoupments

Immediate Recoupment for Fee for Service Claims Overpayments, CR7688:

- CMS will implement the CR7688, July 2, 2012
- The purpose of this Change Request is to implement a standard "Immediate recoupment process." Providers can elect this process to avoid making payment by check and /or avoid the assessment of interest if the immediate offset recoupment pays the debt in full before day 31

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Immediate Recoupments, cont.

If providers request an immediate recoupment they must understand that it is considered a voluntary repayment.

1. Providers who choose immediate recoupment must do so in writing to the contractors.
2. The request will be for a particular overpayment or as a permanent request for all overpayments.
3. By choosing immediate recoupment, providers are waiving their rights to section 935 interest.
4. Providers can terminate the immediate recoupment process at anytime. The request to terminate must be in writing.

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Ways to Request Immediate Recoupments

1. Requesting Immediate Recoupments via website.
   https://www.cahabagba.com/
   Part A - Audit & Reimbursement
2. Faxed Request: (205) 220-9873
3. Send secure Email Request:
   PartA_Immediate_Offset_Requests@cahabagba.com
4. Mail Request:
   Attn: Part A Immediate Offset Request
   Provider Audit & Reimbursement (PAAR)
   P.O. Box 1448
   Birmingham, AL 35201-1448

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Tips for Timely Processing

- Submit only one check for the total amount of the Claim ARs being refunded, a copy of the 1st page of the demand letter and the list of all applicable claims
- When you become aware of a claim overpayment, you are encouraged to initiate adjustments electronically or via hardcopy for outstanding credit balances. If unable to do so, submit a hardcopy UB form containing all claim modifications along with any credit balance report for which adjustments are required

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Resources

- **CMS MLN Matters article:**
  http://www.cms.gov/MLNMatterArticles/downloads/MM7436.pdf

  http://www.cms.gov/MLNMattersArticles/Downloads/MM7499.pdf

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PART 5: CMS RAC PROGRAM

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CMS RAC Program

- Process Overview/Frequently Asked Questions

Presented by Connolly Healthcare
Alyssa Ditzler, Director
and
Dr. James Lee, Medical Director

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Types of RAC Audits

Automated
- No medical records are requested or reviewed
- No review results letter; demand letter is first notice of RAC activity

Complex
- Providers receive an Additional Documentation Request (ADR)
- Requested records must be submitted within 45 days
- RAC reviews records within 60 days of receipt

Semi-automated
- Providers receive an Informational Letter
- Informational Letter is *not* an ADR—providers are not required to send records but may send supporting documentation to dispute RAC findings if desired
- Optional supporting documentation must be submitted within 45 days

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Claims Adjustment Process

1) Review Results letter sent within 60 days of receipt of records
2) Adjustment files sent to payer on weekly/biweekly basis
3) Payer adjusts claim and generates AR (average turnaround time over past 6 months = 15 days)
4) Demand letter is sent by MACS; Connolly receives AR information and posts to portal
5) Recoupment occurs 41 days after demand letter is issued

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Collections

- Payment will be taken back on the 41st day after the date of the demand letter. Interest will begin to accrue on the 31st day.
- Extended Repayment Plans (ERPs) are one aspect of payment processing that is handled by the RAC. The rules governing ERPs are located in Chapter 4, § 50 of the Medicare Financial Management Manual, Pub. 100-6:

https://www.cms.gov/manuals/downloads/fin106c04.pdf

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Top Region C Review Concepts

- *Automated*
- Medically Unlikely Edits
- DME billed while beneficiary was an inpatient

Complex

- Medical necessity of acute inpatient admission for neurological disorders (MS-DRGs 094, 095, 177, 178, 179, 488, 489, 539, 540, 689, 690, 857, 862, 863, 864, 865, 866, 868, 872, and 977)
- Medical necessity of percutaneous cardiac procedures (MS-DRG 249)

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Under New SOW, RACs will Review SNF, Home Health Payments

- Approval pending for Connolly's SNF concepts
- Reviews may focus on admission, skilled services criteria
  - Medicare Benefit Policy Manual, Pub. 100-2 (IOM), Chap. 8, Sec. 10, 20, 30
  - 42 CFR 409.20-409.36

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RAC Discussion Period Exists until Recoupment Occurs

- Providers may discuss a claim with the RAC from the time the review results letter is received through the 40th day after the demand is issued
- Please submit a detailed description of the issue using Connolly's Discussion Request Form, located at http://www.connolly.com/healthcare/Documents/Connolly%20Discussion%20Request.docx
- Fax the request, along with all relevant supporting documentation, to 203-529-2995

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Q&A: RAC Discussion Period

Q: "I had a favorable discussion but my money was still taken back. Why?"

A: Once a claim is sent to the payer, the recoupment cannot be stopped. Retractions are sent to the payer on a weekly basis and the payer must readjust these claims manually. The readjustment process typically takes 3-4 weeks.

Q: "Will I get a letter verifying the discussion outcome?"

A: Yes. The auditor will fax his or her findings to the provider upon rendering the decision. A formal letter will be sent once the readjustment comes back from the payer.

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Q&A: RAC Discussion Period

Q: "How long does it take to receive a response from the RAC?"

A: Per the RAC Statement of Work, Connolly has 30 days to respond to a discussion request.

Q: "What is the difference between the RAC discussion period and the rebuttal period?"

A: CMS grants providers an opportunity to submit a statement and/or evidence within 15 days of the demand letter stating why the proposed recoupment should not take place. The rebuttal process is NOT a discussion, nor does it extend the provider's appeal timeframes.

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CR-7436 & MM7436: On January 3, 2012, MACs Began Sending RAC Demands

- CR-7436: On January 3, 2012 –All MACs began issuing RAC demand letters. MACs will:
  - *Establish the AR and send demand letters following process similar to MAC 935s*
  - *Answer providers' administrative concerns regarding recovery timeframes and appeals*
  - *MAC demand letters will include RAC contact information*
- Connolly will:
  - *Continue producing Review Results letters for complex reviews*
  - *Answer provider questions / concerns regarding the adjustments*
  - *Produce Review Results letters with adjustment rationale for automated and semi-automated claims.* ***Adjustment rationale content is available for secure review on our Provider Portal.***

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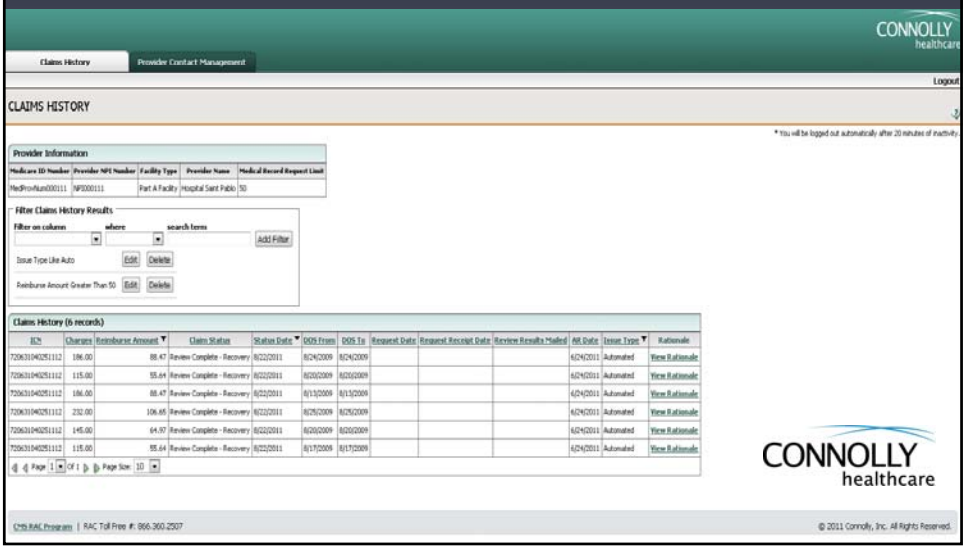
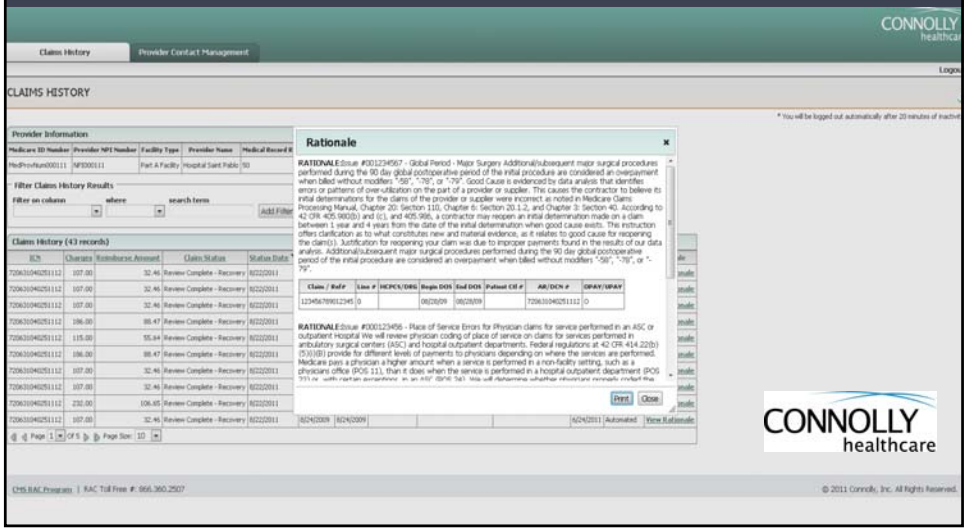
RAC Portal Changes – Login Requires State/Provider#

Portal Includes Information On All Claim Types



Rationale/Claim Line Info Shown For All Review Types



Important Information on Connolly's Website and Provider Portal

- Connolly's approved issues are sortable by claim type, review type, and date of approval.
- Providers can now find claim and concept-specific notes in the Portal
- Connolly's website includes detailed instructions and forms for submitting contact information, including the Multi-Provider Contact Spreadsheet:

  http://www.connolly.com/healthcare/pages/ProviderContactInformation.aspx

  http://www.connolly.com/healthcare/pages/RecordSubmission.aspx

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Q&A: Records Reimbursement

Q: "Can Connolly add the date that copy/postage checks are mailed to the provider on their website?

A: This information should be available in the next portal release

Q: "What is the calculation for medical record reimbursement?"

A: Per CMS policy, Connolly reimburses hospitals $0.12 per page and first class postage for inpatient records only

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Electronic Records Submission Options

- CD / DVD delivery in Metadata format
- Direct link between Connolly & HealthPort
  - http://www.healthport.com/esend
- CMS esMD Program – Connolly is now receiving records via esMD
  - http://www.cms.gov/esmd/

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Additional Links

- RAC Statement of Work:
  http://www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf
- PIP Provider Information:
  http://www.cms.gov/Recovery-Audit-Program/Downloads/RACfaq.pdf
- Discussion vs. Rebuttal Guidelines:
  http://questions.cms.hhs.gov/app/answers/detail/a_id/9994/kw/RAC%20discussion
  http://questions.cms.hhs.gov/app/answers/detail/a_id/9863/kw/RAC%20discussion
  http://www.cms.gov/Recovery-Audit Program/Downloads/ProviderOptionsChart.pdf

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Connolly's Medical Necessity Team

- Medical Director
- CMD
- Appeals Team
- Discussion Team
- Medical Necessity Chart Reviewers

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Medical Necessity Audit Requirements

- Use the appropriate staff
  - —All RNs
- Be as accurate as possible (quality over quantity)
  - —Let the medical record speak for itself
  - —Make only reasonable inferences based on clinical background
  - — Make no assumptions for poor documentation
- Use commercially available products as items in our tool box

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Sources of Audit Concepts

- CMS regulations / publications / manuals
- CERT / OIG / ZPIC reports
- LCDs / NCDs

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Medical Necessity

- A complex review to determine if the beneficiary's condition meets the Medicare medical necessity criteria for the setting where the service was rendered.
  - e.g., A beneficiary presents to the emergency room with SOB that can be safely and effectively treated in an outpatient setting. The hospital admits the patient as an inpatient. The claim could be denied as medically unnecessary for that setting.

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Medical Necessity

- "Medical necessity" is the standard terminology that all health care professionals and entities will use in the review process when determining if medical care is appropriate and essential.

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Conducting a Medical Necessity Review

- Medicare's legal and regulatory documents and policies are utilized as guidelines for decision-making, e.g.,
  - National Coverage Determinations (NCDs)
    - Developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device. NCDs generally outline the conditions for which a service is considered to be covered (or not covered).
  - Local Coverage Determinations (LCDs)
    - Decision by a Fiscal Intermediary (FI) or carrier whether to cover a particular service (intermediary-wide or carrier-wide) or whether the service is reasonable and necessary
  - Clinical support software products as screening tools
- The final determination is based on clinical judgment

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RN's Role in Medical Necessity Review

- Validates demographics, dates of service and claim ID
- Reviews attestation sheet, discharge summary, H&P and ER record (if indicated) to obtain an overview of the case
- Evaluates physician orders, progress notes, operative reports and diagnostic testing results

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Elements of Medical Necessity Determination – IP Admission

- Emergency department treatment
  - Diagnostic tests
    - Clinical significance?
    - Therapeutic significance?
  - Did the patient improve clinically? Symptoms resolve?
- Hospitalization required versus outpatient
  - Diagnostic studies- hospital versus outpatient
  - Laboratory examination to rule out?

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Admission Note/ H&P

- Does record support the need for inpatient admission based on:
  - Plan for care
  - Diagnostic studies
  - Therapeutic decision
  - Treatment changes

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RAC Medical Necessity Reviewers Utilize CMS Manuals

- For IP admissions, see
- Medicare Benefit Policy Manual (Pub. 100-02), Chapter 1, Section 10
- Medicare Program Integrity Manual (Pub. 100-08), Chapter 6, Section 6.5.2

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Discussion Period

- Discussion form
  - Used to provide new information that explains why inpatient admission required
  - Dedicated team is in place to respond to requests
  - All discussion forms reviewed by physician
- Providers can request physician-to-physician discussion *even if* they have already received a written response

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Contact Connolly

- Phone: 866-360-2507 x4
- Fax: 203-529-2995
- Email: racinfo@connollyhealthcare.com
- Website: http://www.connolly.com/healthcare/Pages/CMSRACProgram.aspx or http://www.connolly.com/rac

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Questions

Please direct claim specific questions to the Provider Contact Center at 1-877-567-7271

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Thank You!
Teleconference Participants Only:
Please complete the electronic evaluation upon exiting
Exit
OR
Submit your evaluation by using the following link:
http://listmgr.cahabagba.com/subscribe/survey?f=1381