Event Title: Short Stay Review Update
Event Date: 9/19/2016

Speaker	Transcript
Operator	Today's conference is scheduled to begin momentarily. Until that time your lines will be on musical hold. Good afternoon. My name is Kelly, and I will be your conference operator today. At this time I would like to welcome everyone to the Short Stay Reviews Update conference call. All lines have been placed on mute to prevent background noise. If you should need assistance, press star zero on your telephone keypad and an operator will assist you. Thank you. Scott Fortin, Senior Communications Director, you may begin the conference.
Scott Fortin	Thank you, Kelly, hello everyone. Thank you for joining us today on our webinar. We would like to talk to you about the Short Stay Reviews and will update you on the latest as far as Short Stay Reviews. Speaking to us is Cheryl Cook, Program Director for Areas 2 and 4. A few housekeeping items to go into before we go into the presentation. The slides are available. If you look into the chat, it gives you the direct link at www.keproqio.com. We will record the call, and we will handle any questions for this. We will not open the lines and will take any questions in the chat at the appropriate time. When prompted, you may ask the questions in the chat. We will collect the questions taken in the chat today and tomorrow, and we will be providing written responses to those questions to everyone via the website as soon as we can get them completed. I would ask you limit the chat box to the questions as Cheryl is going to present. And with that, I will turn it over to Cheryl Cook, Program Director for Areas 2 and 4.
Cheryl Cook	Thank you, Scott for the introduction. I greatly appreciate that. Welcome to the Short Stay Reviews Update program. On today's call, we have over 1000 people who have registered, and we welcome each and every one of you who are attending. My name is Cheryl Cook, Program Director for KEPRO Areas 2 and 4. The goal is to provide the community with the latest information related to the Short Stay Review process, the process for handling such reviews, and to provide the community with a few tools, which may assist the hospital community. As mentioned, the call is being recorded and will be posted to our website, which is www.keproqio.com. To protect the clarity, we have muted all the calls, but we would also ask you, as a participant, to mute your own line as an additional precaution in order to preserve clarity for future use of the recording. Due to the size of the audience and being mindful of everybody's time constraints, KEPRO will not open the telephone lines at the conclusion of the presentation. During the course of the program, if you have a question, we encourage you to use the chat feature of the program to submit your questions. Once we have all of the questions, we will provide written answers to those questions. So with that, let's get down to learning about the Short Stay Reviews. KEPRO recognizes your time is valuable and, as such, we strive to make the best use of it. The objective of the program today will include that the participants will be able to identify the Beneficiary and Family Centered Care Quality Improvement Organizations, or what we commonly refer to as the BFCC-QIOs, areas of responsibility, key personnel, to articulate the review

	process, and understand the opportunities to provide additional information for these reviews and to reiterate the appeals process itself. Prior to August 1, 2014, CMS contracted with many companies to conduct what they called mandatory reviews. These reviews encompassed Medicare beneficiary or representatives' complaints regarding the quality of healthcare services provided to them; beneficiary and representatives' request for an expedited review of either a pending hospital discharge or the discontinuation or termination of skills services in the post-acute environment, such as skilled nursing facilities, home health agencies, hospice, and comprehensive outpatient rehab facilities. In addition to these reviews, contractors also reviewed medical records associated with hospitals requesting a higher reimbursement from a previously submitted and paid claim. They also reviewed potential quote unquote dumping of patients in and out of emergency departments as well as various types of reviews. At the same time, these contractors, or state-level contractors, also did large population-based data-driven quality improvement projects, which were aimed at systemic changes within a given provider community. Over the years, these projects varied, including projects such as those that are associated with the reduction in the use of restraints in a skilled nursing facility, reducing the number of central line bloodstream infections, and healthcare acquired conditions. In the earlier Scopes of Work, particularly 7th and 8th Scope of Work reports from the Institute of Medicine and government accounting office were done, which resulted and identified concerns related to the appearance of a quote conflict of interest within the same contractor doing both the mandatory reviews as well as quality improvement projects. With that information in mind, CMS went about evaluating and restructuring the QIO program. What occurred August 1, 2014, was a result of such restructuring or reengineering. The Beneficiary and Family Centered Care QIO or medical record review contract was reduced from a total of 53 to 5. The Quality Innovation Network QIO or quality improvement contracts were reduced from a maximum of 53 down to 17. Contractors were allowed to bid on both the BFCC-QIO as well as the QIN-QIO contracts, but they were not awarded both of these types of contracts. These actions moved CMS from a state-specific contractor to an area or regional-specific contractor. Like many other companies, KEPRO bid on both types of contracts and was awarded three of the five BFCC-QIO areas, and as you can see on this service map, KEPRO has the main southeast areas of the U.S., while the other contractor was awarded the northeast and western portions of the U.S. Both contractors now conduct all mandatory reviews that were previously done at a state level and now also include the Short Stay Reviews. KEPRO is an organization that has three offices that conduct this work located in Cleveland, Ohio; Harrisburg, Pennsylvania; and Tampa, Florida. The Short Stay Reviews, however, will be centralized and will be processed out of the Tampa office. So as you can see from the slide, KEPRO identified key personnel for the project. Before going on, I want to take a few moments to introduce our team to you.

	First and foremost is the Chief Medical Officer, Ferdinand Richards III. Dr. Richards has been about the managed care and fee-for-service peer-reviewed activity since 1988 and has been the Chief Medical Officer for KEPRO since 2014. Prior to 2014, he served as the Chief Medical Officer for the Florida QIO contractor for approximately 18 years. He's very knowledgeable in all aspects of Medicare medical case review and oversees the physician review aspect of the Medicare contract. Dr. Richards represents KEPRO as a presenter and a panel member at CMS sponsored meetings. He is board certified in internal medicine and is a practicing emergency department physician at Tampa General Hospital, which is a level I Trauma Center here in Tampa. Since 1991, he has also been an Associate Clinical Faculty member, Department of Internal Medicine at the University of South Florida College of Medicine. Marianne Lehman is our Clinical Review Operations Manager, and she has more than 30 years of nursing experience and more than five years of progressive leadership experience at the QIO. Prior to joining KEPRO, she oversaw the appeal review operations for the states of Florida, Arizona, and California, and as a subcontractor, she oversaw the review for the states of Georgia, North and South Dakota, Washington, and Idaho. She serves as a subject matter expert for the hospital discharge appeals and required medical necessity reviews, which are associated with the traditional Medicare beneficiary hospital discharge reviews. Steven Dicksen is RHIA with more than 37 years of coding experience and is currently responsible for the operational oversight of all reviews associated with hospital requested higher weighted reimbursement for KEPRO and serves as a subject matter expert for medical necessity and coding reviews here. Mr. Dicksen has been instrumental in the development of the return on investment or ROI reports which are provided to CMS and outlines the dollars returned to the Medicare Trust Fund as a result of technical coding changes and/or medical necessity reviews. Lastly, as I mentioned before, my name is Cheryl Cook and I am the Program Director for KEPRO Areas 2 and 4. I bring 15 years of experience working with CMS leadership, various CMS contractors, and serve as a subject matter expert for all required medical record review processes associated with the QIO program. Prior to joining KEPRO, I led the activities associated with transitioning the second largest state, California, from its incumbent contractor to a new contractor in 2008 and was responsible for building relationships with California provider communities and the Medicare health plans. I led the review activities for the states of Florida, Arizona, California, as well as subcontracted with appeals for the states of Georgia, North and South Dakota, Washington, and Idaho. Along with the state-level medical record review work, I led the Beneficiary and Family Centered Care National Coordinating Center, which is a national team that provided support to both CMS leadership, as well as to the other state QIO contractors during the 10th Scope of Work. All of this to say that KEPRO is well-suited to assume the leadership role that is associated with Short Stay Reviews. We have assimilated a review team that has more than 100 years of experience in utilization reviews, coding, and provider education.

	In the 2015 proposed OPPS Rule, CMS took the opportunity to announce changes to its approach to educating providers and enforcing the application of the rule. The BFCC-QIO contractor, rather than Medicare Administrative Contractors or Recovery Auditors, would now conduct the first line of medical reviews of hospital providers who submitted claims for inpatient admissions. Throughout the years, the QIOs have demonstrated significant history and success in collaborating with hospitals and other stakeholders to ensure high quality of care for the Medicare beneficiary. You might ask why is this process needed at all. In order to answer that question, let's review a little bit of the history of the Two-Midnight Rule and review and the reasons for the implementation. In recent years, and through the Recovery Audit program, CMS identified high error rates for hospital services rendered in a medically unnecessary setting, for example, inpatient rather than outpatient billing status. CMS also observed a high frequency of beneficiaries treated as hospital outpatients and receiving extended observation services or time spent as an observation status. Hospitals and other stakeholders expressed concern, especially since the days spent as a hospital outpatient, or for an observation status, do not count toward the quote qualified three-day inpatient hospital stay that is required before a traditional Medicare beneficiary is eligible for Medicare coverage of skilled nursing facility services. To provide greater clarity to hospitals, physicians, and stakeholders and address the high frequency of beneficiaries being treated as hospital outpatients, CMS adopted the Two-Midnight Rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria that should be used when determining whether inpatient admissions is reasonable and payable under Medicare Part A. In general, the Two-Midnight Rule stated that inpatient admissions will generally be payable under Part A if the admitting practitioner expects the patient to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. Medicare Part A is generally not appropriate for hospital stays not expecting to span at least two midnights. The Two-Midnight Rule also specified that all treatment decisions for beneficiaries were based upon the medical judgment of physicians and other qualified practitioners, and the Two-Midnight Rule did not prevent the physician from providing any service at any hospital regardless of the duration or the expected duration of that service. As part of the policy change, CMS instructed various other contractors as to their role and responsibilities with the policy change. Specifically, Medicare Administrative Contractors were instructed to and had been providing or performing prepayment patient status probe reviews on a sample of 10 claims for most hospitals, and 25 claims for larger hospitals, with dates of admission on or after October 1, 2013. These quote probe and educate reviews were conducted to assess the provider's understanding and compliance with the final rule. Based on the results of the initial reviews, the MACs continued to conduct individualized educational efforts and repeated the process where necessary. CMS has been working with the MACs to assure accuracy of claims review and identify any recurrent provider errors.

	A few examples of findings that were reported by the MACs include, and I will give you three patient scenarios. Here a patient presented to the emergency department and was complaining of chest pain. The physician's notes stated the patient was going to be worked up, but it was unlikely the pain was cardiac in nature. The physician's order stated admit to observation. The beneficiary was kept overnight and discharged the next day. The hospital submitted a claim for a one-day inpatient stay. Upon review of the claim, the MAC denied the claimant because it lacked the order to admit. The second scenario presented included a procedure in which treatment and discharge typically occurred in less than two midnights and the procedure itself was not on the inpatient-only list, and the physician wrote an order to admit to inpatient upon arrival at the hospital for preoperative care. The medical record did not support the expectation of a Two-Midnight Rule stay for hospital care, and the beneficiary underwent the procedure without any complications either during or after the procedure and was discharged within 10 hours of arrival to the hospital. The hospital submitted a claim for a zero day inpatient stay. Upon review of the claim, the MAC denied Part A payment because medical records failed to support an expectation of a Two-Midnight Rule. The last scenario is where a Medicare beneficiary presented to the emergency department with recent onset of dizziness and denied any other complaints. The beneficiary reported a recent adjustment in his blood pressure medications. The physician's notes stated that the beneficiary was stable and blood pressure medicine was to be held and dosage adjusted. The notes also indicated that the physician intended to observe the beneficiary overnight and the beneficiary was discharged the next day. The hospital submitted a claim for a one-day inpatient stay and upon review of the claim by the BFCC-QIO, denied Medicare Part A because the medical record failed to support expectation of a two-midnight stay. In the draft of the rule, CMS proposed changes to the quote probe and educate process based upon extensive stakeholder feedback. To develop and publish such changes to the rules, CMS gathered intensive information and feedback regarding the rule and regarding the educational process from multiple stakeholders, and the stakeholders included but are not necessarily limited to: • Hospitals, both individual or freestanding, those that were associated with health systems, appropriate elder facilities • Hospital associations • Physicians • Medicare Payment Advisory Commission or commonly referred to as MedPAC • Beneficiary advisory groups and • Members of Congress as well. With all of the background information in mind, what are the changes that occurred as a result of the OPPS Rule?

	First and foremost, the review responsibility shifted from the MAC to the BFCC-QIO contractors on October 1, 2015. The focus of the BFCC-QIO contract review would be primarily for the hospital stays which were zero to one day in length since the review responsibilities shifted prior to the publication of the 2016 OPPS Final Rule. The BFCC-QIO contractors would review records according to the payment policy that was in place at the time so, for example, for any reviews that were done between October and December 2015 it would be based upon the policy that was in the 2013 rule. However, beginning hospital stays that had an admission date on or after January 1, 2016, the contractors would apply the policy that was in effect as a result of the new change, meaning that we would apply the 2016 OPPS Rule changes. The BFCC contractors began the Short Stay Reviews on October 1, 2015, and data was made available to the contractors through CMS' data contracts/contractors. At KEPRO, in order to manage the high volume reviews that were to be done, we determined that we would make weekly claim selections and send medical record requests out to those involved providers. It was our way of being able to manage the volume and to hopefully keep things streamlined. KEPRO completed the reviews and we made our initial determinations known to the involved hospitals via written communication and, if applicable, we provided one-on-one provider education sessions, while hospital representatives could also provide us with additional information or insight on a specific claim. At the conclusion, KEPRO would make the final determinations known to hospitals. After participating in many provider education calls and in response to stakeholder feedback, CMS issued a stop work order on May 4, 2016. This was done to ensure consistency and compliance among its contractors, including the BFCC-QIOs as well as others. Both contractors participated in several in-service education sessions, which were led by CMS leadership. We were required to provide 10 charts per area that were reviewed under the old policy that which was in effect between October-December 2015, as well as providing an additional 10 charts per area that had been reviewed under the new policy, meaning for those dates of service that were on or after January 1, 2016. CMS also provided guidance to the contractors regarding those cases that were still in some step of this process, meaning that a final determination letter has yet to be mailed to the hospital. As noted on this slide, any cases that were in the process were removed from the providers' sample, and letters were generated and mailed to hospitals to indicate that the Part A payment was still in effect. For those cases where a final determination had been made and a letter generated, contractors were advised to notify the involved hospitals that these cases were to be re-reviewed. Once completed, the hospital would be notified of the contractor's final decision. As of September 12, 2016, all CMS required instructions and guidance had been completed by both contractors, and CMS issued instructions to once again begin these reviews. Round two has been restarted with a new time frame of September 2015 through February 2016. Contractors will not be requesting medical records with a date of service that is beyond six months look-back, so anything in September that might be requested cannot have an admission date prior to April 2016. As part of our provider education plan, this program would be

	recorded and provided to the community via the website, which is but one outreach activity that KEPRO will use to spread the information about this review and about the changes in the policy. We have had the time to look at the information about the background of the reviews and what has transpired within the past year, and now let's talk about the review process itself. Hospitals that will be included in the process remain those in acute care, long-term acute care, and inpatient psychiatric facility. Hospitals excluded from the process will continue to be the critical access hospitals and inpatient rehab facilities. At this point, it should be noted that while critical access hospitals, or more commonly referred to as CAHs, are included in the requirement for the Two-Midnight Rule, they are excluded in the claim selection and review process. How will KEPRO process the short stays? CMS provides us with a universe of claims from which the BFCC-QIO will select and request medical records from associated hospitals. The sample size remains the same. It is 10 claims for an average size hospital, 25 claims for a larger hospital, and this is going to be done every six months. There is one file per state, and those hospitals that fill their threshold of 10 claims or 25 claims will be the ones that we select and review from. All of this information is pulled from CMS' claims data warehouse. One of the things that should be noted is the claims should not contain stays with inpatient only procedures associated with them. However, this does happen from time to time and when it does medical records are typically excluded from our review. We do want to also state that hospitals will have 45 days in which to submit their medical records to KEPRO, and then the QIOs will have a maximum 45 days to complete their review. While making the universal claims available to the QIOs, we do want to let you know some of those things that would be excluded from here. So for example, claims in which there is a disposition code of 07 which is AMA, 20 which is expired, 02 discharge or transfer to a short-term, or general hospitals or even 5051 which is discharging to hospice. Those are typically excluded from universal claims that we get. Claims that involve procedures as I mentioned on the inpatient only list, other quote do not pursue claims; these are claims that may be associated with the hospital provider that is on a pre-existing agreement based upon the Zone Program Integrity Contractors, or the Benefit Integrity Support Center. The BFCC-QIO will be responsible to verify if a provider is on a pre-existing agreement prior to initiating a request for medical records. We will receive information from our Contracting Officer Representative on a regular basis with lists of those types of providers that have been deemed not to pursue, and if these claims were selected, they would be excluded. And then lastly, any claims that were associated with indirect medical education, Medicare Advantage, or where Medicare was a secondary payer will also be excluded from these reviews. Once the claims have been identified and selected, KEPRO will forward to the hospital provider a request for the associated records. This activity will be completed within five business days of the receipt of the claim universe. Within the medical record request, KEPRO will provide a due date for the receipt of these requested records, and this was typically going to be 45 days from the date of our medical record request. Should the provider fail to provide the requested medical records within 45 days, it could be denied due to the lack of medical records. However, KEPRO will utilize several reminder

	techniques for the hospital communities. Such reminders include sending out letters, making telephone calls, even utilizing the educational sessions to remind hospital providers to submit all requested medical records. Once the record is received, it could reverse a previous denial due to missing records. Medical records will be accepted in the CMS approved format; such formats include encrypted CDs, fax transmissions, uploaded through the esMD or via hard copy. To assist the providers, KEPRO has established a dedicated fax line that can be used by the hospital community, and that number is posted on this slide, and it is 844-242-2568. Ideally, KEPRO would like to receive requested medical records in digital electronic format; however, we will not restrict the provider's ability to submit medical records in any of the CMS approved formats. Once medical records are received, contractors will have 45 calendar days to review and to make their initial determinations. All of the submitted medical records will be screened for an appropriate inpatient admission order and the length of stay, looking for all possible times the patient was in the facility, including time in the emergency department, observation status, and inpatient status. And the records will be screened to determine the reasonableness of inpatient admissions based upon the data and the information the attending practitioner had at the time the inpatient order was written. Inpatient admission orders continue to be required for all admissions per CMS guidance that was published in January 2014. As a condition of payment for hospital inpatient services under Medicare Part A, Section 1841 A of the Social Security Act, it requires physician certification of the medical necessities that such services be provided on an inpatient basis. The order to admit as an inpatient, which is known as the practitioner's order, is a critical element for the physician's certification. It is therefore required for hospital inpatient coverage and payment under Part A. The physician certification, which includes the practitioner's order, is considered along with other documents in the medical record as evidence that the hospital inpatient services were reasonable and necessary. When a physician signs the certification, they are that certifying inpatient hospital services were reasonable and necessary. Requirements for inpatient admission orders can be found at the link noted on the slide, but basically know that the practitioner's order must specify admission for inpatient services, must be furnished by a physician or practitioner who is licensed in the state to admit patients, have hospital privileges to admit patients, and have knowledge of the patient's condition, his or her hospital course and or plan of care. When assessing for the two midnight benchmark, KEPRO will look at the total time the patient has been in the facility. This could be spent in the emergency department after his or her arrival to the room, time spent in observation status, and time spent after the formal inpatient order was written. KEPRO reviewers know that unless admission involves services listed on the inpatient only list, Part A payments isn't generally appropriate for length of stay of less than two midnight. Under CMS revised policy, admissions less than two midnights may be appropriate on a case-by-case basis, where the medical records supports the physician's decision that the patient required inpatient care. And we are aware the BFCC-QIO will take into consideration the complex medical factors, the severity of illness and signs and symptoms, current medical needs and the risk of an adverse event to determine if the

	medical records support inpatient admissions. For those patients who come into the hospital for surgical procedures, testing, or any other treatment, and the practitioner has an expectation that their stay will be more than two midnights, it is generally appropriate for inpatient payment under Part A. That said, there are times when some unforeseen circumstance results in a state that is less than two midnights, and yet the hospital payment may still be appropriate. Such circumstances include but are not exclusive to the patient's death, perhaps patient transfer to another facility, another hospital, patient may have left against medical advice, or perhaps the patient improves more quickly than anticipated following surgery or some type of invasive procedure. And then the patient may elect the hospice benefit in lieu of continuing hospital care. The Two-Midnight benchmark is based upon a practitioner's expectation that medically necessary hospital services beginning with a formal written admission order will span over two midnights. The BFCC-QIO contractors are aware that the decision to keep the patient in the hospital and the expectation of needed care is based on many complex medical factors and will consider all such factors in making the determinations. And as a reminder to the audience, practitioners and physicians are not required to document the expected length of stay, as this information can be inferred from the medical record documentation. Lastly, the BFCC-QIO contractors will review for the reasonableness of inpatient admission. Contractors are aware that reasonableness is based on the knowledge that that practitioner had at the time the inpatient order was written. The patient order should be based upon the lab results, or the x-rays, or any and all data that the physician or practitioner had at the time the inpatient admission order was written. It is expected, however, that the medical necessity and the reasonableness would be supported by the medical record documentation. For reasonableness of inpatient admissions, the contractors will continue to follow the guidance that CMS provided where payment would be prohibited. Those things include care rendered for social reasons, or for convenience, or where they may be excessive delays in providing medical necessary care, such as those patients that might require invasive or diagnostic procedures such as heart catheterizations, CT scans, MRI, those that have to wait a prolonged period., typically over one weekend before those procedures are done. Those delays would not necessarily be reasonable, for the patient and would not factor into the admission. Without accompanying medical conditions, factors that cause inconvenience in terms of time and money do not justify Part A payment for continued hospital stay. On this particular slide, CMS has provided the contractors with flowcharts as to the expected method for reviewing short stay claims. The above process has been incorporated into KEPRO's internal review processes. Hospitals can find this document posted on CMS' website, which is www.qioprogram.org. It outlines the steps that are to be taken by the contractors and provides an algorithm of how those decisions are made. KEPRO will utilize its review results letter to communicate to the individual hospital its results. The initial review results letter will be detailed and include an individualized claim by claim denial rationale and will include written clinical details. Such details are valuable and can be used as a basis for any follow-up discussions between KEPRO and the hospital provider. KEPRO will utilize a

	letter to remind hospital providers of those records, which have yet to be received and reviewed by the QIO. Additional steps will be necessary based upon the initial review results of BFCC-QIOs. CMS has provided outcome certification for BFCC-QIOs “next steps”, which may be different from that which was previously used by the MAC contractors. For those providers with a denial rate of less than 10% of the reviewed claims, which CMS defines as a minor concern, KEPRO will educate the provider using its initial review results letter. This letter will be mailed to the hospital provider at the conclusion of the review process. The provider will have an opportunity to discuss the results with the BFCC-QIO. Typically this is achieved through written correspondence, but we are available to speak with that individual hospital if warranted. Providers with the denial rate of more than 10% but less than 20% of the reviewed claim, CMS has defined this as a moderate concern, and KEPRO will educate the provider using once again its results letter. In addition, KEPRO will offer to educate the provider on a one-on-one basis via telephone. This educational session will provide an opportunity for open dialogue to discuss the review results of each claim. Providers with a denial rate of more than 20% of the reviewed claim, which CMS defined as a major concern, will once again receive education from KEPRO through its results letter. In addition, KEPRO will schedule a one-on-one session with the provider to be conducted via telephone within 90 days of completing the review. Unlike the optional education opportunity outlined in a minor or moderate concern, KEPRO shall educate the provider regarding the major concern. All educational sessions will be designed to be interactive between KEPRO and a healthcare provider, and it will provide an opportunity for the hospital to review KEPRO's claim decisions, ask questions, and receive additional feedback that is conducive for behavioral change and to increase the provider's compliance with the application of the two midnight benchmark. And, it is KEPRO's goal to establish an environment that is really conducive for dialogue. These educational sessions will be collegial in nature, and we would encourage the healthcare provider to include any and all staff members to join the telephonic sessions. As part of the education sessions, KEPRO will invite CMS to the call and will ensure that healthcare providers are aware that CMS may be listening in on our calls. And for provider situations where there appears to be a pattern of noncompliance and a denial rate that is greater than 20%, KEPRO may refer providers and claims to the Recovery Auditors, or the RACs, for implementation of provider-specific audits. However, at this moment in time the BFCC-QIOs are working with CMS to determine the definition of a pattern of noncompliance and the denial thresholds for such referrals made to the RACs. It's KEPRO's goal to minimize the number and frequency of referrals made to the RACs and to work with hospitals to improve their internal processes surrounding the appropriate billing status and the application of the Two-Midnight Rule. KEPRO's philosophy is that effective outreach and communication is ongoing education is imperative to the success of the Medicare Beneficiary and Family Centered Care program and intends to expand its communication to accomplish the Short Stay Reviews. KEPRO will reach out to the provider community through its dedicated educators in order to build and foster continuous dialogue and to ensure better relationships, so that all parties are working together to improve efficiencies and effectiveness in healthcare

	delivery. Opportunities for discussion will take place with hospitals in order to provide any additional information which may be used by KEPRO before reaching its final determination. These discussions and educational sessions will also be used to remind hospitals once again to submit any outstanding records which have yet to be received and reviewed. With each of these opportunities in educational sessions, CMS leadership will be invited to attend, and they may participate as they desire. In addition, KEPRO has proposed to CMS leadership that it would host general education and training sessions on a regular basis in order to improve additional education. During the sessions, KEPRO's team proposes to provide the identified data trends, best practices, and lessons learned. This opportunity is under consideration by CMS leadership, and once the decision is made we will communicate that out to the hospital community. We will utilize other methods to assist in the spreading of information; methods include but are not limited to our newsletter, electronic newsletter, e-mail blasts, website postings to update providers on the identified data trends, best practices and outcomes. As part of our education strategy, KEPRO will develop a final results letter for all providers after the completion of the medical record review and the opportunity for discussion or the educational sessions have been completed. These letters will provide detailed results, which will include individualized claim by claim denial rationale. As noted on this next steps slide, the BFCC-QIO will be required to forward noncompliance claims and/or missing medical denials to the Medicare Administrative Contractor or MAC. They will have the responsibility for making any and all final adjustments for these claims, and in addition, hospitals will have an appeal process which will be facilitated by the MAC. KEPRO's final results letter will provide hospitals with information regarding the steps to take in order to activate the appeal process with the MAC contractors. As I previously mentioned, we do have a responsibility to refer noncompliant providers to the Recovery Auditors. Again as I mentioned, we are still working on a definition on compliance and working with CMS to kind of flesh out a definition as well as the threshold that might be considered a pattern. Please note that no referrals to the MAC will be made without CMS involvement and guidance. As I mentioned before, it is our goal to minimize the number and the frequency of referrals that are made to the RAC and to work with hospitals to improve your own internal processes surrounding the billing status and the Two-Midnight Rule. We do have some additional information that you can find on our website. This is going to be one mechanism that we will use to update the provider community. You will find that updated information on that website and you will also find resources such as the October 2015 guidance; January 2016 guidance that will be on the website, as well as other links for this type of information. We will be providing a frequently asked page on this website. We will take all of your questions that you have submitted both for this session and

	tomorrow's session, and we will formulate answers to those questions, and we will publish it on this website as well as other vehicles. There is also a form on this website that you can update your own organization's contact information that is specific to the Short Stay Reviews. We are well aware there are hospitals and hospital organizations that have dedicated people assigned to working these types of appeals as well as those reviews you may get from a MAC or a RAC. If the individual is different than your QIO Liaison, we would highly encourage you to go to the website and download this form and provide us with the information. This will help us to be able to get the letters out to you more quickly as well as to make sure we are contacting the right people to set up the educational sessions. Before we conclude this call, I do want to provide the hospital community with contact information related to KEPRO's Short Stay Review team. We have developed a virtual mailbox that can be used by any hospital provider when you are inquiring about a status of a review. This mailbox is available to many team members that can answer that question and provide you with feedback quickly. For questions that are related to the medical records selection and documentation request, we would ask that you contact Steven Dicksen; his contact information is on this slide. For any questions that are related to medical reasonableness, or perhaps the application of the Two-Midnight Rule, we would ask that you contact Marianne Lehmann. For any administrative type questions that you may have, feel free to contact me. And then for clinical decisions, if you have questions about clinical decisions, our Medical Directors are available for discussion with hospital representatives and/or your hospital Medical Director. We are certainly very open to have dialogue with hospitals, and we encourage you to contact us with any questions that you might have. For the hospital community, we have provided resources on this slide. You would be able to go right here and gather some additional information that we feel is pertinent to our review that is being done. So we highly encourage you to use that. At this point, being mindful of individuals and the time constraints, it does conclude our call. We hope the information has been informative for you. We hope that you have submitted questions through the chat feature, and that feature will be open for a few minutes after the call has concluded. Please feel free to submit your questions in that chat feature, and we will take those and answer them. We really do want to take this opportunity to thank you for connecting with you and your organizations on this particular subject. Our team hopes we have been able to provide you with information that will be pertinent to the work that is going to be done and resumed here shortly. We appreciate the feedback that you all have given to us as we were performing the reviews previously, and we look forward to continued collegial and interactions with you. So with that, I'm going to conclude today's call and say thank you very much for attending. We appreciate it.
Operator	And this concludes today's conference call. You may now disconnect.

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