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Prevent Denials and Win Appeals

The Hospital Case Manager’s Guide to Revenue Integrity

Paul Arias, RN, BSN, MIS
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About the Author

Paul Arias, RN, BSN, MIS, is the senior director of case management at Inova Fairfax Hospital in Falls Church, VA. He was most recently the director of care coordination at Crouse Hospital in Syracuse, NY, which maintained a denial rate of less than 1% and a 72% reversal rate under his leadership.

In more than 14 years as a nurse, Arias has been primarily in leadership roles, including ED assistant manager, critical care director, and chief executive nurse/director of patient care services. He was a copresenter for HCPro’s audio conference "Prevent Denials through Case Management."
Introduction

The purpose of this book is to provide you with information that will lead to a successful implementation of a denial prevention and recuperation program. For years, hospitals have been held liable for a loss of payment because of a lack of medical necessity, demonstrating why a patient needed an admission to an acute level of care. Hospitals have struggled to devise programs to ensure payment, and most efforts have been concentrated on the back end; however, denial prevention begins at the point of entry. As you read through this book, envision the program from the point the patient enters the facility all the way to the payment from the insurance carrier. Many of the topics discussed are tried-and-true methodologies that have led to successful outcomes as the author implemented or assisted others in implementing the strategies outlined herein.
CHAPTER 1

History of Medical Necessity
Medical Necessity Overview

Medical necessity is used in today’s healthcare environment to dictate and drive the cost of care so that it is spread as evenly as possible for all beneficiaries. By dividing the cost of care in an even distribution pattern based on medical necessity, insurance companies maintain that they can better serve their members and have sufficient funds to meet the demands of care. From a denial management perspective, medical necessity is one of the most important elements to grasp to be successful in capturing reimbursement for medical services. Denial prevention and money recuperation starts with understanding the importance of a medically necessary admission and continued stay and the documentation that is required to be in the medical record to ensure timely and appropriate payment.

The Creation of Medical Necessity

The conundrum of medical necessity is how it is defined. To better understand the definition, we must first look at its creation.

During the 1940s, medical insurance plans became a part of the American healthcare system, and medical necessity became an inherent part of the system in order to provide cost savings and spread the ability to provide care for many. The determination of the necessity of care was still relegated to the judgment of the treating physician. The Social Security Act of 1965 established Medicare and Medicaid, and in 1966, Medicare was fully implemented. To control costs, certain mandates were enacted, and by 1972 it was required that each admission to an acute care hospital be reviewed for medical necessity. Under the
Medicare and Medicaid program, the judgment of the physician was placed under scrutiny. Although the program’s admitting criteria still observed the physician’s judgment as being paramount in the ability to admit a patient, there was a need to look at how admission decisions were made across physician practices. Oversight of the program included a mandate that payment would be made only for appropriate and medically necessary care.

Defining Medical Necessity

Medical necessity was established by Medicare as a means to provide cost-effective care and prevent the treating physician from indiscriminately requesting admission or continued stay. The use of professional services and the need for diagnostic tests also came under scrutiny. The Social Security Amendment contained the provision that “health services ordered for government patients are provided economically and only when, and to the extent, medically necessary” (Blanchard, 2004, p. 601). The problem with that provision was that no true definition of medical necessity was provided. The interpretation held by many was that the government wanted to ensure that physicians provided care “in the context of the shortest, least expensive or least intense in terms of level of treatment of care or service provided” (Blanchard, 2004, p. 601).

Concurrently in the 1970s, private insurance companies began to require that physicians justify their care decisions. This change in practice by the insurance companies led Medicare to begin to issue coverage determinations and start a list of noncovered services. Also thrown into the fray were the Medicaid programs in each state. Some of their definitions included language such as “accepted medical practice or community standards of care; not for the convenience of the patient or provider; not experimental or investigational; and appropriate and effective” (Bergthold, 1995, 180).

The Supreme Court joined in the discussion in 1977 in the case of Beal v Doe (U.S. 438, 444), stating that medical necessity within Medicaid programs, known as Title XIX, “conferred broad discretion on the states to adopt standards for determining the extent of medical assistance.” The court further stated that “nothing in the language of Title XIX requires a participating state to fund every medical procedure falling within the delineated categories of medical care. Each state is given broad discretion to determine the extent of medical assistance that is ‘reasonable’ and ‘consistent with the objectives.’” The court also stated that “the Social Security Act does not require participating states to fund every medical procedure falling within delineated categories of medical need, but each state is given broad discretion to determine extent of medical assistance that is reasonable and consistent with objectives of the Act, and, although serious questions might be presented if state Medicaid plans did not cover necessary medical treatment, it is not inconsistent with the Act’s goals to refuse to fund unnecessary, though perhaps desirable, medical services.” Again there was a failure to describe or determine medical necessity.

In 1980, in the case of Pinneke v Preisser (623 F 2d 546, 550), the 8th Circuit Court of Appeals recognized that “the decision of whether or not certain treatment or a particular type of treatment is medically necessary rests with the individual recipient’s physician and not with clerical personnel or government officials.”
In 1998, the AMA released the following definition of medical necessity:

Healthcare services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily ... for the convenience of the patient, treating physician, or other healthcare provider (AMA Policy H-320.953, 1998).

Most healthcare plans followed suit and provided similar definitions that included provisions to:

- Prevent the onset or worsening of an illness, condition, or disability

- Provide palliative, curative, or restorative treatment for physical and/or mental health conditions

- Establish a diagnosis

- Assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age (Blanchard, 2004, p. 602)

As recently as the Clinton administration, a better definition of medical necessity was debated in Congress, but no consensus was reached. Language in the debate included “effective,” “beneficial,” and “judicious.” Each of these terms carries its own interpretation that can be ambiguous and can lead to further confusion. What is “beneficial” and to whom is the benefit applied? What about “judicious”? How would that apply to the beneficiary, versus what the plan determines to be judicious? Because there were many stakeholders, each with their own needs and agenda, including the different political parties, the drive to create a national health plan that included a working definition of medical necessity died a slow death in Congress.

At the same time, private insurance companies began to list covered and noncovered services and procedures in their summary plan descriptions.

Further moves to define medical necessity have remained stagnant for some time. Private insurers continually use the term as a means to direct the review of any claim, which can be a prospective, concurrent, or retrospective review. These same companies have added another layer to medical necessity by publishing internal guidelines on what are or are not covered items and relegating them under the umbrella of a medical necessity review. These guidelines are most often based on each company’s own research of evidence-based medicine, but, as a point of interest, they seldom include research conducted in other countries, which limits the scope of accepted practice. What one company deems investigational under its medically necessary care may have been a prescribed treatment regime in other countries for years.
**Medicare and medical necessity**

Medicare has published its latest version of medical necessity in the *Medicare Benefit Policy Manual* (Pub 100-02). It is defined not in terms of medically necessary care but in terms of who inpatients are and how physicians must judge who is to be admitted. Medicare defines inpatients as follows:

> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient’s care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark—that is, they should order admission for patients who are expected to need hospital care for 24 hours or more and treat other patients on an outpatient basis.

However, the decision to admit a patient is a complex medical judgment that can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s bylaws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services to assist in assessing whether the patient should be admitted (i.e., performing the studies does not ordinarily require the patient to remain at the hospital for 24 hours or more);
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

According to Medicare:

Admissions of particular patients are not covered or are noncovered solely on the basis of the length of time the patient actually spends in the hospital. The intermediary does not deny an admission that includes covered care, even if noncovered care was also rendered. Under PPS, Medicare assumes that it is paying for only the covered care rendered whenever covered services needed to treat and/or diagnose the illness were in fact provided. If a noncovered procedure is provided along with covered nonroutine care, a DRG change rather than an admission denial might occur. If noncovered procedures are elevating costs into the cost outlier category, outlier payment is denied in whole or in part.

*(Medicare Benefit Policy Manual, Pub 100-02, pp. 4-1–4-2, Aug. 2005)*
The outlined terms lead one to believe that the judgment of the physician is the determining factor to meet medical necessity for admission and to prevent a denial. In general practice, a physician’s judgment is generally insufficient if it is not accompanied by documentation of a potential adverse outcome and the description of a patient’s clinical status as acutely ill and receiving treatment at an acute level of care. How a physician or a case manager should document the patient’s clinical status in the medical record will be covered in depth in later chapters.

**ERISA and SPD**

An additional source of information on how to define medical necessity can be found in the Employee Retirement Income Security Act (ERISA) regulations. ERISA required companies that provide insurance for purchase by their employees to generate a summary plan description (SPD) that contains information on how the plan works, how to file a claim, what services are covered and noncovered, and how determinations are made, to name a few of the standards. Within most SPDs, there is generally a section on medical necessity. The following is typical information contained in SPDs:

**Medically necessary (medical necessity)**
The determination of medical necessity is made by the applicable healthcare company. Care is considered medically necessary if it:

- Is accepted by the healthcare profession in the United States as appropriate and effective for the condition being treated
- Is based upon recognized standards of the healthcare medical specialty involved
- Represents the most appropriate level of care: the frequency, duration, and site of services, depending on the seriousness of the condition being treated (e.g., in the hospital or in the physician's office)
- Is not experimental or investigative

The need to define medical necessity grew into a new resource business. Around 1972, the need to define medical necessity for admission and continued stay created a need for a standardized set of guidelines, or criteria, on which the decisions could be made. Rather than having a specific hospital-based nurse review the admission and make an arbitrary decision, companies began to collect data and review accepted standards. InterQual criteria, among some other small or legacy criteria sets, began to be used. It was important for case managers to have some backing in the review process when making a determination that a specific patient did or did not meet admission criteria. Physicians were still involved in the process, but it was very important to have a neutral guide, or criteria, on which to base decisions.

Most insurance companies follow these definitions, but now add the use of criteria sets (e.g., InterQual or Milliman Care Guidelines) under the guise of establishing medical necessity derived from evidence-based medicine and research.

Perhaps in the future, if medicine in the United States becomes more uniform, a standardized definition will exist, and as such, those who deal with medical necessity denials and those who wish to prevent denials will have a working definition of medically necessary care regardless of where they come from. In the
meantime, it is essential to use the definition of medical necessity as delineated by the authority that you rely on for reimbursement and work within that parameter. Chapter 3 will discuss detailed methodologies on how to apply medical necessity criteria to prevent and overturn denials.

Hospital-Based Case Management

Case management has been in existence in the hospital setting for more than 20 years. New England Medical Center in Massachusetts is among those credited with establishing the first case management model. The medical center was able to develop a clinical case management approach by using CareMaps, which had well-defined patient interventions from admission to discharge (Roggenkamp, White, and Bazzoli, 2005). From that original hospital model a variety of practices have been developed. A review of the literature reveals that no consistent definition of a case management model exists, but rather that many organizations have used a combination of organizational structures and models.

The initial impetus to create a hospital-based case management department was primarily driven by cost. Case management has been in existence since the early 1900s with social programs and progressing to insurance companies to assist in cost containment. The hospital case manager (CM) position had its roots in both areas, as well as being propagated due to institutional influences to achieve the same level of success as a facility's competitors. Hospital CMs now focus on many areas that include a "collaborative process that assesses, plans, implements, coordinates and evaluates the options and services required to meet an individual's health needs using communication and available resources to promote quality and cost-effective outcomes" (Powell and Ignatavicius, 2001, p. 3). Within the current practice, hospital CMs have progressed to specialized areas within their scope of practice to include disease- or population-specific practice, utilization review (UR), discharge planning, clinical documentation, and coding, among others.

In the United States today, emergency departments (ED) face unprecedented challenges. Increased volume, consumer expectations and publically reported scorecards, regulatory compliance, insurance coverage determinations, and fiscal responsibility are among the myriad obstacles that must be navigated for EDs to be considered successful. The new paradigm of customer expectations for high-quality care in a setting that allows for quick turnaround, while not missing vital information, can put a strain on the capabilities of any well-run ED. The question that EDs across the country are asking is how to manage the challenges and be fiscally successful. One solution that many are implementing is ED case management. Case management has been a successful part of the hospital setting. In the past decade there has been an increase in the number of facilities using case management in the ED. The 2009 American Case Management Survey reported that 83%–85% of facilities with bed capacity from 200 beds to more than 500 beds had ED case management. Of those reporting that they do provide case management in the ED, there was a lack of dedicated emergency room case management and only an average 52% cover on Saturdays and 46% on Sundays both had 91%–95% responsibility to assist in other areas of the hospital.

Why have EDs moved to use case management? The benefits are numerous. Some of the advantages are
History of Medical Necessity

in the ability of the CM, using the UR process and criteria, working with physicians to determine appropriateness of admission to acute inpatient status or to suggest admission to outpatient observation service, and assessing patients for post-discharge needs prior to inpatient admission. All of these processes support meeting compliance to standards of practice such as The Joint Commission, and Centers for Medicare & Medicaid Services (CMS), and the Social Security Act’s Condition of Participation that the discharge process begin at admission. Working to avoid medically unnecessary or inappropriate admissions is the first step in preventing denials. ED case management involves monitoring patients who are frequently readmitted, sometimes referred to as “frequent flyers.” This critical intervention can be a valuable link to community resources. Identifying patterns and trends in the use of ED services can lead to quality improvement efforts that are also among the duties of the ED CM.

**Discharge planning**

Discharge planning is essential to the role of any successful hospital. Postacute care planning is needed to maintain a length of stay (LOS) that is consistent with severity and case mix. Financial stability comes from managing utilization and patient days. In the ED, this translates to ensuring that a CM obtains vital data that start the discharge process. Opportunities to communicate with family members or the healthcare proxy may be lost or delayed once the patient is admitted, thus delaying the discharge process. As Bristow and Herrick noted, ”The process of case management focuses on the coordination of healthcare services to facilitate cost-effective, positive patient outcomes. Having patients and family members actively participate in the planning process enhances compliance with the discharge plan” (2002). The ED CMs can assess for placement issues and durable medical equipment or home health needs, thus assisting the in-house CM in the discharge process. The ED CM can also assist in placing patients directly from the ED without the need for a costly inappropriate admission, which leads to the prevention of a denial. Proactive discharge planning drives throughput and assists with LOS. Early identification of patient needs and the expected LOS can influence the expectations of the patient, family, and medical team to meet the clinical goals for treatment. The information gathered can also influence the case management care plan.

**Utilization review**

UR is a cornerstone of ED case management. As gatekeepers, CMs have knowledge of admitting criteria and can assist the ED physician in making the determination for placement. As noted by Romania, ”Case managers can assist admitting physicians with identifying patients that do not meet acute care admission criteria. Once this is determined, efforts are then made to seek out the appropriate level/place of care for the patient” (2006). Placement in skilled nursing homes, psychiatric facilities, drug and alcohol rehabilitation, and shelters are among the discharge locations that a CM can assist with, thereby preventing unnecessary admissions and increasing throughput by saving a bed for those meeting admission criteria. This also helps prevent an admission denial and lack of reimbursement.

**Observation status and the RAC**

The ability to review admissions leads to savings because it enables placement of the patient at the correct level of care. Using observation service for those patients who meet the criteria can save the hospital money by decreasing denials. As Gautney et al. noted, ”Each year nationally, about 600,000 chest
Chapter 1

Pain patients are admitted to the hospital for inpatient care and are later diagnosed without any significant disease” (Gautney, Stanton, Crowe, and Tracey, 2004). With a new focus through recovery audit contractor (RAC) reviews, the need to properly admit patients is more crucial to keep the reimbursement that was billed. One- and three-day and inappropriate admissions are on the RAC radar. The days of not using observation service because Medicare only reviews 50 charts per month is over. RACs can go three years in their review and will issue denials for improperly admitted patients. Thus, the chest pain patient who should have been a one-day observation stay but who instead had a full admission and workup will be reviewed and result in a potential denial. Other diagnoses and symptoms fit the category of inappropriate admissions, such as abdominal pain, headaches, the so-called “failure to thrive,” and the infamous “unsafe to discharge.” Bringing a patient in for a three-day qualifying stay to access the Medicare Extended Care Benefit without meeting admission criteria also places the facility at risk for a denial. A pattern of this practice may also be reviewed for quality of care and potential fraud allegations. This is where the CM can intervene for placement directly from the ED. The ED CM can gather the necessary information for discharge planning if the patient is admitted and place the patient into the correct admission status to ensure correct reimbursement.

Many hospital financial departments are leery of using observation services due to the minimal reimbursement that goes along with it. The risk-reward benefit of placing the patient into a full admission was on the reward side due to the lack of audits conducted by Medicare. However, RAC audits have changed the landscape of the reviews being conducted by Medicare. A report published on the RAC demonstration project in February 2008 states that 3.9% of the Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing, or payment rules. That equates to $10.8 billion in Medicare fee-for-service (FFS) over- and underpayments. In 2006, Congress required that the U.S. Department of Health and Human Services make the RAC program permanent and nationwide no later than January 1, 2010.

**Fiscal integrity**

Improper payments can occur in the Medicare FFS program when payments are made for services that were not medically necessary or did not meet the Medicare medical necessity criteria for the setting where the service was rendered.

In 2007, $99.2 million in payments were retracted following the RAC audits from inpatient hospitals in New York. Heart failure and shock accounted for $7.8 million of the overpayments collected by the RAC audits.

How can case management assist with the RAC? Reviewing admissions for proper inpatient or observation status and placement is key to decreasing the risk of a medically unnecessary denial. The ED CM should be an expert in admitting criteria, whether InterQual, Milliman, or national coverage determinations, as well as being able to articulate this to the admitting physician. A bond must be created within the ED to ensure that the ED CM is apprised and involved in the admission process.

“Frequent flyers” consume a lot of ED resources. A patient usually is tagged as a frequent flyer if he or she has three or more visits per month. Assumptions are sometimes made about the frequent-flyer patient
because of the nature of the relationship that is created by the frequent visits. However, many of these patients have several comorbidities, poor living conditions, addictions, and afflictions that undermine their health, often coupled with an inability to seek and get care outside of the ED. Effective ED CMs will be able to intervene by exploring community-based resources, making clinic appointments, helping to secure financial assistance, and providing education. Although further investigation is needed to positively state that ED case management is a benefit, case management interventions have proven to decrease readmissions. Thus, it can be stated that interventions in the ED as listed earlier can lead to similar results.

Hospital case management will continue to develop, and facilities must stay abreast of regulatory changes that can impact the financial health of the institution. Economic forces are currently making all health-care facilities in the United States reevaluate their processes to cut or eliminate cost. Emphasis should be on reduction of potential revenue loss. Preventing denials through the use of hospital CMs is one method facilities can use to do this.

The Birth of Evidence-Based Criteria

Prior to the development of criteria that supported decision-making in regard to who to admit and when to discharge, the discretion fell solely on the treating physician. Because there was no oversight, admissions, discharges, and LOS varied across geographical areas as well as between physicians.

With the establishment of Medicare came regulations such as “each provider organization was required to have an admissions committee to review medical necessity of admission, the length of stay, the discharge practice and the necessity of the services requested by the physician” (Mitus, 2008).

At the time Medicare began the regulations, providers turned to the Professional Activity Study (PAS) book, which was a compilation of data from medical record information that was computerized and received through a voluntary exchange. The information gathering began in 1953. The PAS had three components: basic data, patient care data, and optional concurrent review data used for UR. The optional data elements were number of days spent in care units, whether consulting physicians were used, and the total charges for the hospitalization (Mullener and Kobrinski, 1983). It was from these data that hospitals began to look at comparative LOS data. However, guidelines for best practice were lacking. The information provided was simply historical in nature and did not have benchmarks.

Other limitations of the PAS included the collection of the data and the analysis based on coding that was not uniform, creating discrepancies as high as 43% mostly based on the selection of the primary diagnosis (Luft, 1983).

At the time that PAS was being used, other companies were developing and selling criteria to assist in utilization decisions. In addition, an amendment in 1972 to the Social Security Act authorized the creation of professional standards review organizations (PSRO), which were set up to cut costs and to monitor medical necessity and improve the quality of the care being provided. Public Law 92-603 stated in section 249F that PSROs be set up “in order to promote the effective, efficient and economical delivery of health care services of proper quality for which
payment can be made, in whole or in part, under the Social Security Act ... " (California Medicine, 39).

In 1973, a nurse named Joanne Lamprey, along with attorney Charles Jacob and a physician, responded to a government request for proposal for assistance in developing a quality assurance program. Lamprey’s work as a UR nurse allowed her to recognize the failures of the PAS and the need to create better criteria for UR. Jacob had been working with The Joint Commission when he met Lamprey, and shortly thereafter started what would become InterQual. They published their first set of criteria for Severity of Illness and Intensity of Service in 1978 (Mitus, 2008).

During this time frame, the HMO Act of 1973 was established with the hopes of decreasing cost, but in essence it raised cost to individuals.

The proliferation of managed care organizations (MCO) in general, and HMOs in particular, resulted from the 1965 enactment of Medicare for the elderly and Medicaid for the poor. Literally overnight, on July 1, 1966, millions of Americans lost financial responsibility for their healthcare decisions. Offering free care led to predictable results. Because Congress placed no restrictions on benefits and removed all sense of cost-consciousness, healthcare use and medical costs skyrocketed. Congressional testimony reveals that between 1965 and 1971, physician fees increased 7% and hospital charges jumped 13%, whereas the consumer price index rose only 5.3%. The nation’s healthcare bill, which was only $39 billion in 1965, increased to $75 billion in 1971.

As patients have since discovered, the HMOs—staffed by physicians employed by and reporting to corporations—were not much of an improvement in the management of healthcare delivery. HMOs sell coverage of services, but because of the criteria established for appropriateness of coverage, they often deny coverage or access to the listed benefits. HMOs, like other prepaid managed care products, require enrollees to pay in advance for a long list of routine and major medical benefits, whether the healthcare services are needed, wanted, or ever used. The HMOs manage care and control and determine access to healthcare service through definitions of medical necessity, restrictive drug formularies, and HMO-approved clinical guidelines (Blaise, 2001).

PSROs have evolved into quality improvement organizations (QIO), and HMOs and PPOs have propagated to include Medicare Advantage plans, each with their own review process, guidelines, and evidence-based criteria to determine the medical necessity of a patient’s care. As proof of the proliferation of evidence-based criteria guidelines, one of the largest and most successful QIOs, the Island Peer Review Organization (www.iapro.org) in New York, uses Milliman Care Guidelines (www.careguidelines.com) as a screening tool to provide guidance on when and who to admit, as well as where to discharge patients.

The quandary for hospitals is that there is more than one set of criteria, each with their pros and cons. One of the biggest cons is the cost associated with leasing the guidelines. Few hospitals can afford to have more than one set of criteria and therefore run the risk of
incorrectly interpreting medical necessity based on the insurance provider’s choice. Evidence-based research is a valuable tool in providing care that is proven to work, but when that same evidence is used to deny reimbursement, those in a position to stop and or appeal a denial can find themselves grasping for guidance on how to proceed. Throughout the next chapters, you will learn methods for decreasing the potential for a denial, how to use the evidence-based guidelines in a beneficial manner, and when to appeal with the use of those guidelines.

Summary

Medical necessity is the foundation of denial prevention. Understanding the history and significance of the terms that outline the criteria used by insurance companies, regulatory bodies, and government entities is crucial in establishing a denial prevention program and having the ability to overturn denials on appeal.

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