MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid

Recovery Audit Contractor

FREQUENTLY ASKED QUESTIONS

August 2015 (Version 1.0)

Office of the Governor, Division of Medicaid
550 High Street, Suite 1000 | Jackson, Mississippi 39201
Website: www.medicaid.ms.gov

1. **What is a Recovery Audit Contractor (RAC)?**

   Section 6411 of the Affordable Care Act (ACA) expanded the current RAC program to Medicaid and Medicare Parts C and D. The legislation calls for states to:

   - Contract with RACs in order to identify overpayments and underpayments by the state Medicaid agency, and to recoup overpayments;
   - Create processes for entities to appeal adverse determinations made by RACs; and
   - Coordinate recovery efforts with other governmental entities performing audits, including federal and state law enforcement agencies such as the FBI, HHS, and the state Medicaid Fraud Control Unit.

   The RAC program was implemented to protect the Medicaid program from fraud, waste and abuse, through the reduction of improper payments by providing efficient detection and collection of overpayments and identification of underpayments. The RAC reviews claims on a post-payment basis to detect and correct past improper payments so Medicaid can implement actions that will prevent future improper payments. Improper payments are classified as overpayments and underpayments.

2. **How does the Recovery Audit Program affect me?**

   If your claims are chosen for a RAC-initiated audit, you will be notified in writing and given instructions as to the appropriate steps to take. If the claim is determined to have been paid incorrectly, you will receive written notification of the findings. In situations where more information is needed to determine if the claim was paid correctly, you will receive a letter asking for additional medical information to validate the claim payment. Please follow the instructions in the letter to ensure that the information requested is submitted accurately and within the required amount of time.

3. **Is PRGX still conducting RAC audits for MS Medicaid claims?**

   As of June 30, 2015, Division of Medicaid contract with PRGX has expired. PRGX has completed reviews of all documentation previously requested. Until further notice, the Division of Medicaid, Office of Program Integrity will review any incomplete audits initiated by PRGX until the RAC work is transferred to another contractor.

4. **Will there be a new RAC auditor for the state of MS?**

   Currently the Division of Medicaid is in the process of procuring another RAC contractor.

5. **What type of claims can the RAC review?**

   All Medicaid fee-for-service claims are within the scope of audit for the RAC. Improper payments can occur as a result of the following:

   - Incorrect payment amounts;
   - Non-covered services (including services that are not found to be medically necessary);
   - Incorrectly coded services; and
   - Duplicate services

   For purposes of the RAC program, an "improper payment" is defined as an overpayment or underpayment. However, if a provider submits a claim with an incorrect code, but the error does not change the payment amount, then it will not be considered an improper payment.

6. **Does the RAC audit include Mississippi Coordinated Access Network?**

   Future audits may include managed care claims data as more and more beneficiaries are transitioned into the managed care program.

7. **What is the time period of audits by the RAC?**

   The RAC must not review claims that are older than three (3) years from the date the claim was filed, unless it receives approval from the State. This is consistent with CFR § 455.508.

8. **What information do the RACs use when reviewing claims?**

   When making determinations, RACs comply with:

   - Mississippi Medicaid Coverage and Reimbursement Policies;
   - Federal & State Regulations; and
   - Standard industry guidelines for evaluating the medical necessity of services

9. **Where can I go to learn more about the types of audits being conducted and about the RAC program in general?**

   Mississippi Division of Medicaid (DOM) provides information on its website at http://www.medicaid.ms.gov/providers/recovery-auditor-contractors/ under Provider Resources which details the latest audits. There are also audit-related FAQs, as well as instructions for responding to medical record requests.

10. **Will the current concepts being audited remain the same?**

    Audit concepts are based on various analytic tools to identify vulnerabilities in the Medicaid Program, which are overpayments that may have occurred. The selection and performance of future audit subjects/concepts will be done in consultation with the Division of Medicaid and the new RAC contractor and subject to the Division of Medicaid, Office of Program Integrity's final approval.

11. **How can providers be sure that future audits are not duplicated?**

    Any RAC contractor is required to coordinate its audits with other auditing entities and meets regularly with DOM to avoid duplication of audits. The entity should not audit claims that have already been audited or that are currently being audited by another entity.

12. **Who pays for the cost to produce requested records?**

    It is the duty of providers to make charts and records available to Medicaid staff, other State and Federal agencies, and its contractors thereof, upon request. Records shall be maintained in accordance with Administrative Code Part 200, Chapter 1, Rule 1.3. If a provider fails to participate or comply with the Division of Medicaid's audit process or unduly delays the audit process, the Division of Medicaid considers the provider's actions or lack thereof, as abandonment of the audit.

13. **Is there a limit to the number of records the RAC can request?**

    The number of records requested by the RAC shall not exceed 2.5% of the volume of claims submitted by the provider in the previous calendar year divided by five waves per year.

14. What type of documentation is required in patient charts?

Documentation included in patient charts will vary depending on the category of service. Typically, patient charts should be maintained in accordance with professional standards, industry guidelines, and Medicaid policy. Unless otherwise specified, providers should submit complete patient records documenting all services which were billed to Medicaid, including supplemental data, such as lab reports, intake forms, prior authorization forms, and other information which justifies the services billed to Medicaid.

15. Who do I call when I have a RAC question?

If you have any questions about the RAC program, please contact the Office of Program Integrity at (800) 880-5920 or locally at (601)-576-4162. Office staff is available Monday through Friday, from 8:00 am to 4:30 pm CST. Staff can assist you with questions about RAC letters, timeframes for responses, and general audit information. Providers can also submit any questions/complaints in regards to the MS Recovery Audit Program to MSRAC@medicaid.ms.gov.

16. To whom must providers send correct contact information to?

If you must make any changes regarding mailing address or point of contact information please contact 1 (800)-880-5920, (601)-576-4162 if you are local, fax at (601)-576-4161 or mail the corrected information to:

Mississippi Division of Medicaid
Office of Program Integrity
Attention: Kameron M. Harris
Walter Sillers Building; 550 High Street; Suite 1000
Jackson, MS 39201

Information can also be emailed to MSRAC@medicaid.ms.gov.

17. What types of determinations may RACs make?

RACs may make any or all of the following determinations:

- Coverage and medical necessity determinations;
- Coding determinations; and
- Improper billings,
- Improper payments (e.g., duplicate claim determinations)

18. How will RACs identify overpayments and underpayments?

The Division of Medicaid supplies the RAC with an initial data file containing claims history followed by monthly updates. The RAC will analyze claims for possible improper payments. Overpayments and underpayments will be identified through three (3) claim review methods – automated, semi-automated, and complex.

19. What is an automated review?

An Automated review will occur when the RAC makes a claim determination by reviewing claims data rather than clinical documentation from the medical record. A RAC may use automated review when making coverage and billing / coding determinations only when there is certainty that the service is not covered or is incorrectly coded and/or non-compliance with Medicaid policy exists.

20. What is a semi-automated review?

In a semi-automated review, the RAC will make a claim determination based on review of claims/billing information. However, rather than immediately denying the payment and initiating recoupment, providers are given the opportunity to submit medical record information to support the allow-ability of the service provided.

21. What is complex review?

Complex review will occur when a RAC makes a claim determination using expert review of the medical record. RACs will use complex review when the requirements for automated review are not met.

22. How long will providers have to respond to medical record requests?

Providers are given thirty (30) days to respond to a medical records request. If a provider does not submit the requested medical records within thirty (30) days, the RAC will initiate contact with the provider as a reminder. If after forty-five (45) days the provider does not submit the requested medical records, the claim will be denied.

23. Will providers receive the results of RAC reviews?

The RAC will advise providers of the results of automated reviews (including any coverage, coding or payment policy or article violated) only if an overpayment determination is made. The RAC will always notify providers of the results of semi-automated and complex reviews even if no improper payment is identified.

24. For complex reviews, what will be the time frame for notifying providers of any overpayment?

In accordance with CFR 455.508, the RAC must complete complex reviews and notify the providers with the review results within sixty (60) calendar days of receipt of the medical records.

25. What if the provider disagrees with the RAC's decision?

Rebuttal: Initiates a discussion period between the RAC and the providers. Providers may respond in writing during the rebuttal period to communicate disagreement with RAC's decision, provide additional documentation, or inquire about the findings.

Providers have thirty (30) days from receipt of findings letter to initiate a rebuttal of RAC's decision. If a provider decides to engage in the Rebuttal, he or she should:

Download the Rebuttal Form at http://www.medicaid.ms.gov/wp-content/uploads/2014/04/RebuttalRequestFormMSDOM.pdf under Provider Resources. Complete the form and provide specific details of case, including relevant documentation to support request. Fax or mail to the Division of Medicaid to begin the rebuttal process; The RAC has forty-five (45) days to re-audit the claim and issue a findings notification. Initiating a rebuttal does not limit a Provider's right to request an administrative hearing.

If You Wish To Request An Administrative Hearing:

If you disagree with the determination and you have received the demand letter, and you wish to request a hearing, please follow the requirements of Title 23, Part 300 of the Mississippi Administrative Code located at http://www.medicaid.ms.gov/AdminCode.aspx

Please submit all administrative hearing requests to:

Division of Medicaid
Division of Appeals
Attn: Tara S. Clark
550 High Street, Suite 1000
Jackson, MS 39201

26. How will overpayments be recouped?

The RAC will communicate the overpayment to the Mississippi Division of Medicaid for validation and adjustment. After findings have been upheld, the RAC will submit

overpayments files to the Office of Program Integrity. If the full claim is in error it will be voided and a credit balance will be established. If the claim is a partial overpayment the provider will be given thirty (30) calendar days to submit a void/adjustment to the Office of Program Integrity. If the provider does not submit a void/adjustment the full claim will be voided. Instructions are included in the demand letter received from the RAC.

Please review the findings letter to identify claims that will require an adjustment/void if indicated. Before resubmitting the claim(s) with the corrections, please be sure to confirm that the Voided Transaction Control Number (TCN) number has been included in the correct field of the resubmitted claim. On the CMS1500 form this would be field 22- ORIGINAL REF. NO, and on the UB04 this would be field 64- DOCUMENT CONTROL NUMBER. Any claims resubmitted with the appropriate field not populated with the Voided TCN number will be rejected. Additionally, please note that these Corrected/Resubmitted claims will be treated as original claims and will be subjected to the complete series of edits and audits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed. Submit any corrections within thirty (30) calendar days of the receipt of the demand letter to the Mississippi Division of Medicaid to the attention of Program Integrity at 550 High Street, Suite 1000, Jackson MS 39201. Include a copy of the findings letter and demand letter.

Adjustment/Void Request Form can be found at:

http://www.medicaid.ms.gov/Forms/ProviderForms/AdjVoid_rev_0306_rev.pdf

27. How will underpayments be handled?

Federal law requires the RAC to identify underpayments to providers as well as overpayments. Underpayments can occur as a result of incorrect coding to claims, claims processing errors or for other reasons. The RAC will communicate the underpayment to the MS Division of Medicaid for validation and adjustment.

28. How can Mississippi Medicaid providers stay informed about the Mississippi Medicaid RAC Program?

Providers can stay informed about the RAC program by periodically checking the Mississippi Medicaid website for news and developments relating to the program. The website is located at http://www.medicaid.ms.gov/providers/recovery-auditor-contractors/ under Provider Resources.

29. How is the RAC compensated?

The RACs only collect fees on overpayments that are recovered and underpayments that are corrected. In addition, RAC contractors must return any recoveries that are reversed after a provider appeal. This means that auditors are incentivized to pursue only those claims they can prove are inaccurate.

30. What happens if the RAC identifies potential fraud?

The RAC must immediately report any potential fraud to the Division of Medicaid. The Office of Program Integrity will follow up with the RAC's fraud referral and decide is a credible allegation of fraud exists. In accordance with 42 CFR §455.508 specifies that states are required to make referrals of suspected fraud and/or abuse as defined in 42 CFR § 455.2 to the MFCU or other appropriate law enforcement agency.