Mississippi Medicaid

Recovery Audit Contractor

FREQUENTLY ASKED QUESTIONS

July 2019

Mississippi Division of Medicaid
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The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

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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. **Who is the RAC contractor for the state of MS?**

   The Division of Medicaid has currently contracted with LaunchPoint Ventures dba Discovery Health Partners.

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

   All Medicaid fee-for-service and managed care 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.

5. 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.

6. What information do the RACs use when reviewing claims?

When making determinations, RACs comply with:

- Mississippi Medicaid Coverage and Reimbursement Policies;
- Federal & State Regulations;
- Standard industry guidelines for evaluating the medical necessity of services; and
- Clinical and payment policies of the contracted managed care organizations.

7. 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 https://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.

8. How are audit concepts determined?

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 are subject to the Division of Medicaid, Office of Program Integrity's final approval.

9. **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.

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

    According to the Mississippi Administrative Code Part 304, Chapter 1, Rule 1.1 D, 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.

11. **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.

12. **Who do I call when I have a RAC question?**

    Please contact Discovery Health Partners with any questions/concerns at (866) 880-0608. Office staff is available Monday through Friday, from 8:00 am to 4:30 pm CST.

    Staff within the Division of Medicaid, Office of Program Integrity can also assist providers with questions about RAC letters, timeframes for responses, and general audit information. Providers can contact Office of Program Integrity staff at (601)-576-4162 or toll-free at 800-880-5920. Providers can also submit any questions/complaints in regards to the MS Recovery Audit Program to MSRAC@medicaid.ms.gov.

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

Providers should expect a forthcoming request to provide updated contact information from Discovery Health Partners. Please make sure to provide contact information for the direct individual who handles Medicaid RAC activities within your facility to ensure the information is forwarded to the appropriate personnel.

14. 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)

15. 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.

16. 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.

17. 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.

18. 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.

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

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

20. **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.

21. **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.

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

Providers are given the opportunity to submit rebuttal request. A rebuttal request initiates a discussion period between the RAC and the providers. If the provider is still dissatisfied with the results of the rebuttal, the provider has an opportunity to request an administrative hearing. Guidance on how to follow these processes will be provided.

23. **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.

24. **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 https://medicaid.ms.gov/providers/recovery-auditor-contractors/ under Provider Resources.