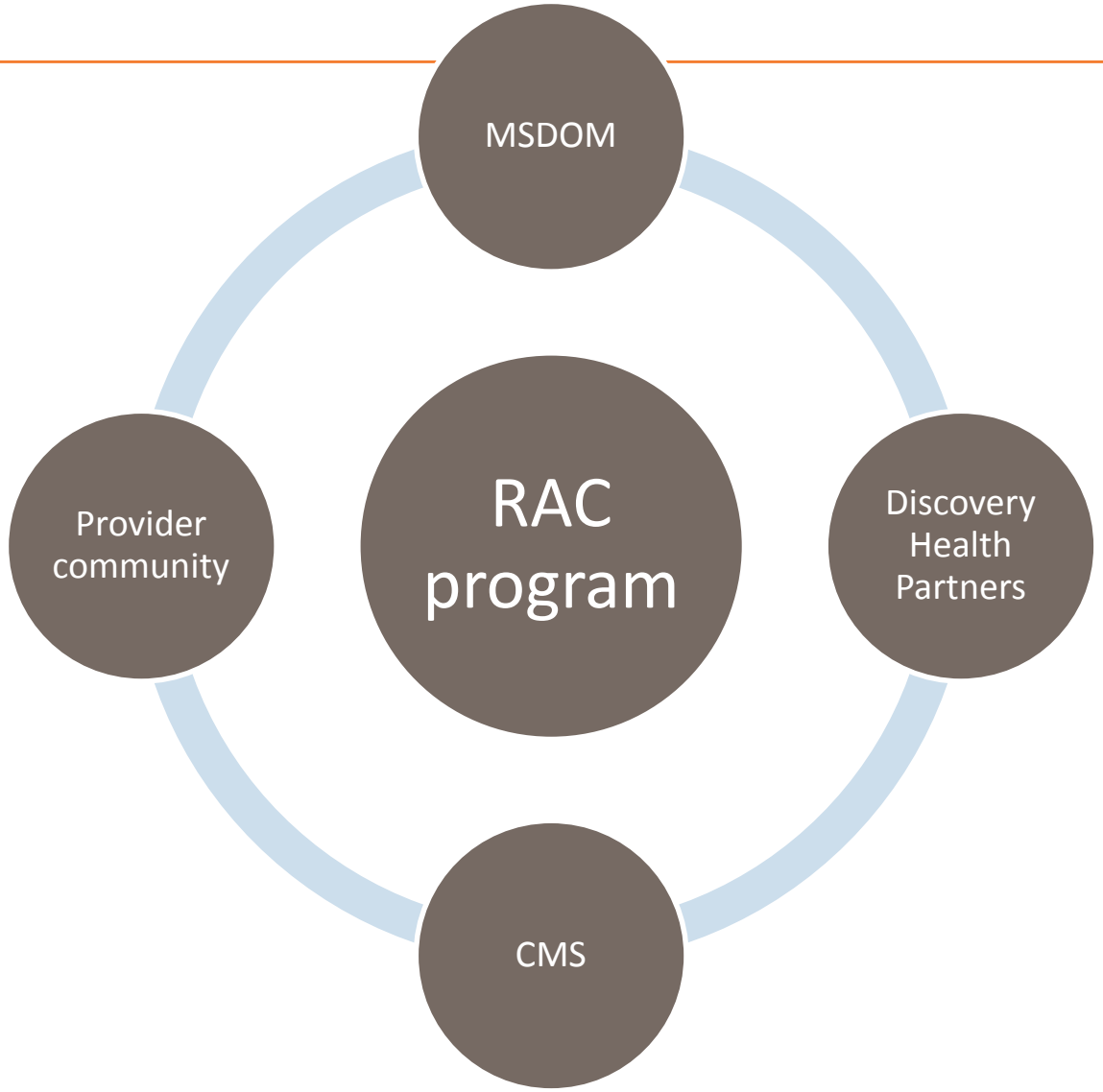
The MSDOM Recovery Audit Program

Provider Outreach

Session agenda

- Overview of the RAC program
- Types of audits
- RAAC correspondence and communications

Stakeholders



Overview of the RAC program

42 CFR 455.502 establishment of program

- The Medicaid Recovery Audit Contractor program (Medicaid RAC program) is established as a measure for states to promote the integrity of the Medicaid program
- States must enter into contracts, consistent with state law and in accordance with this section, with one or more eligible Medicaid RACs to carry out the activities described in § 455.506 of this subpart
- States must comply with reporting requirements describing the effectiveness of their Medicaid RAC programs as specified by CMS

Role of Discovery

- The Recovery Audit Contractor (RAC) Program is a ***supplemental approach*** to Medicaid program integrity efforts
- The RAC's objective is the ***reduction of improper payments*** through the efficient detection and collection of overpayments and identification of underpayments
- ***Outreach and training*** for the provider community on the audit process and strategies for correcting future billing errors

Overview of the RAC program

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

Overview of the RAC program

What information do the RACs use when reviewing claims?

- When making determinations, RACs comply with:
  - Mississippi Medicaid coverage and reimbursement policies
  - Federal and state regulations
  - Standard industry guidelines for evaluating the medical necessity of services

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

Audit types

How will overpayments and underpayments be identified?

Overpayments and underpayments will be identified through three (3) claim review methods—complex, automated, and semi-automated

> **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.

> **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.

> **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.

Audit types

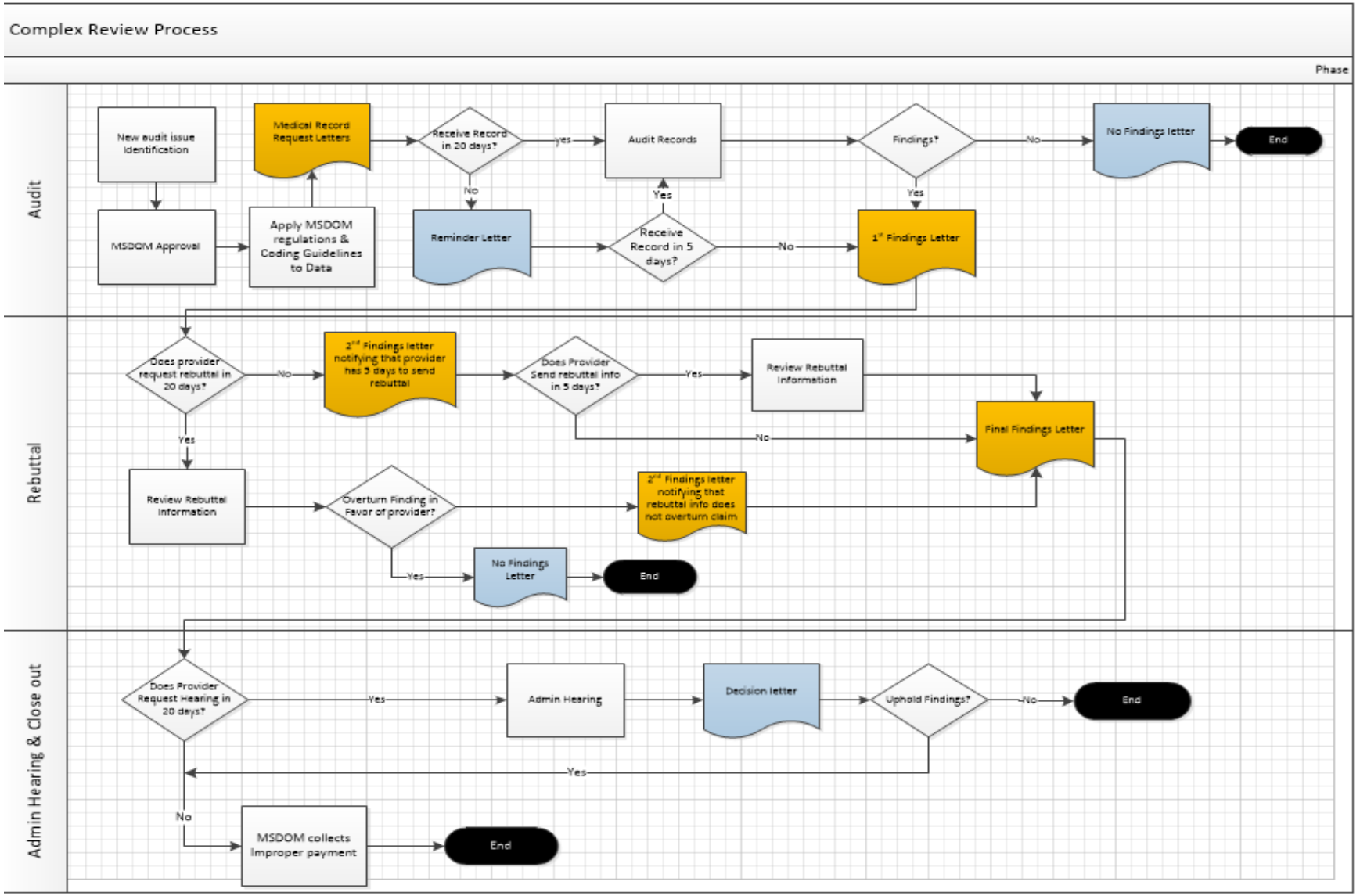
- **Complex reviews**
  - Audits performed by qualified and credentialed professionals through a comprehensive review of medical records/documentation resulting in:
    - Decision regarding claim reimbursement of an improper payment (over/under payments)

      OR
    - Determination that the claim was paid accurately (no finding)

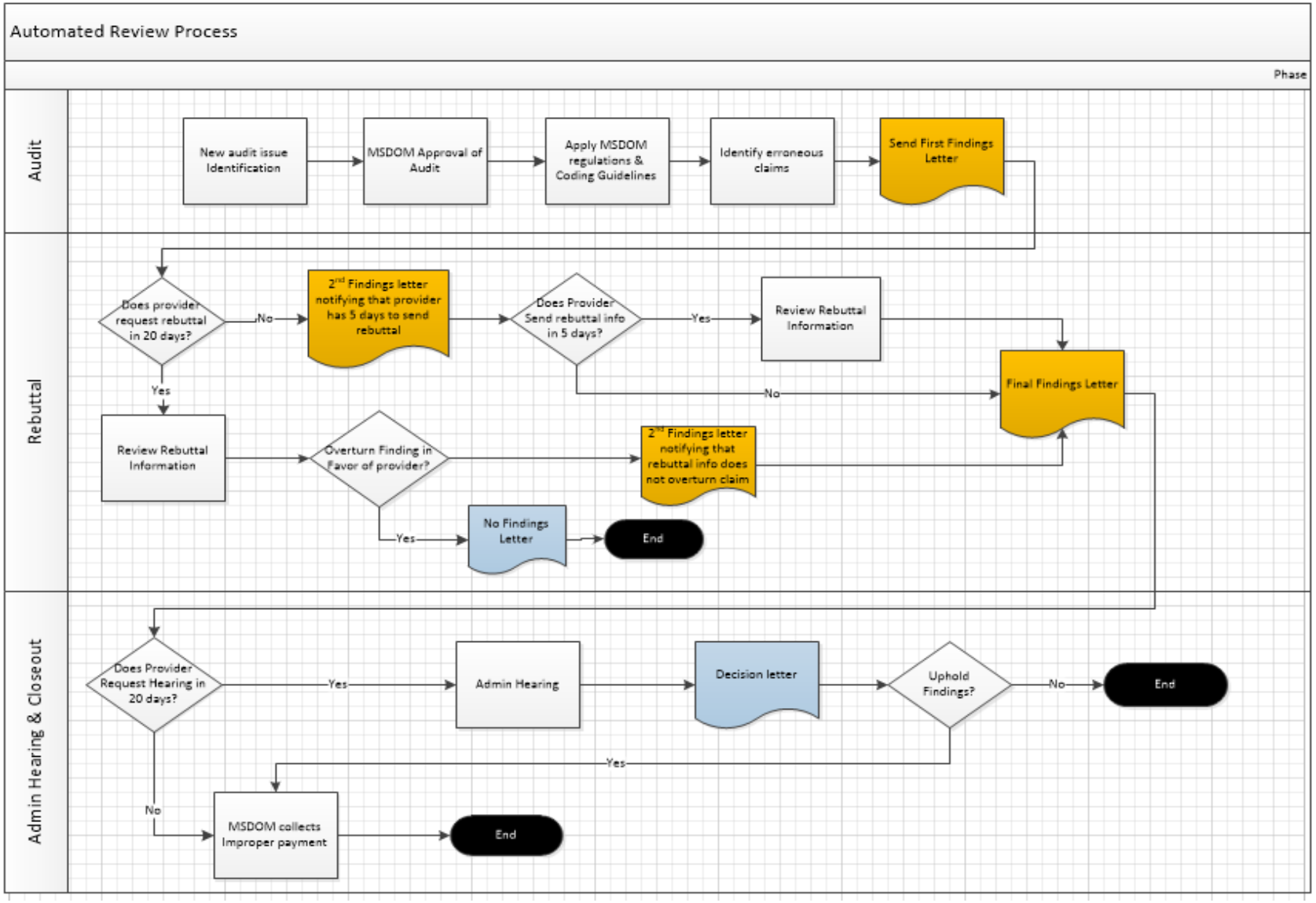
- **Automated reviews**
  - Audits performed by an automated review:
    - Result of clearly identifiable non-covered services, or incorrect applications of coding rules, or service limits
    - Audits do not require a medical record to determine an improper payment (over/under payments)

- **Semi-automated review**
  - Audits performed by an automated review:
    - Result of potentially identifiable non-covered services, or incorrect applications of coding rules, or service limits
    - Audits do not necessarily require a medical record to determine an improper payment (over/under payments)
    - Providers are given the opportunity to submit medical record information to support the allow-ability of the service provided

Audit types | complex review



Audit types | automated review



Audit types

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
  - 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.

Audit types

What types of determinations may RACs make?

- RACs may make any or all of the following determinations:
  - Coverage and medical necessity determinations
  - Coding determinations
  - Improper billings
  - Improper payments (e.g., duplicate claim determinations)

RAC correspondence and communications

Medical record request letter	A letter sent by Discovery to a provider requesting certain medical records to assist with the audit. Providers have **20 calendar days from the date of this letter** to send in the Medical Record to Discovery If requested, providers may receive an extension of **5 additional calendar days.**
Preliminary findings letter	A letter notifying an improper payment and dollar value, or a No Finding, or an error for lack of documentation. This notification will indicate how the provider can enter into a discussion period with Discovery. Providers may submit additional documentary evidence and written argument against the proposed overpayment within 20 days of the date of this letter.
Second notice letter	If after 20 days the provider has not responded to the preliminary findings letter, Discovery will send a second notice letter notifying the provider that they have five additional calendar days to submit information related to the audit This notification contains similar information as the preliminary findings letter.
Final findings letter	A letter notifying an improper payment and recovery process such as offsetting of the improper payment. This letter also informs the provider of the opportunity to request an administrative hearing.

RAC correspondence and communications

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.

RAC correspondence and communications

- Volume of record request
  - Discovery identifies vulnerable claims based on MS Medicaid regulation
  - Discovery selects the vulnerable claims to audit and seeks approval from the MSDOM contract administrator

- Validate your contact Information
  - Ensure your organization identifies one point of contact person
  - Submit contact information via email to MSDOMRecoveryAudit@discoveryhealthpartners.com
  - If point of contact or contact information changes, immediately notify Discovery's Provider Communications Department via mail, email, or fax

Discovery Health Partners
Attn: MSDOM Recovery Audit
32 West 200 South #503
Salt Lake City, UT 84101
Phone: 866.880.0608 Fax: 888.904.8842

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RAC correspondence and communications

- Discussions/rebuttals
  - Initiates a discussion period between Discovery and the providers. Providers may respond in writing during the rebuttal period to communicate disagreement with Discovery's decision, provide additional documentary evidence, or inquire about the findings
  - Providers have **twenty (20) days from the preliminary findings letter** to initiate a discussion of Discovery's decision. If a provider decides to engage in the discussion, he or she should
    - Send Discovery the claim control numbers being rebutted
    - Include relevant documentary evidence to support request
    - Fax or mail listed information above to Discovery's Provider Communications to begin the discussion process
  - If after 20 days, the provider has not responded to the preliminary findings letter, Discovery will send a second notice letter notifying the provider that they have five additional calendar days to submit information related to the audit
  - Initiating a discussion does not limit the provider's right to request an administrative hearing

RAC correspondence and communications

- Appeals
  - Providers may request an appeal with the office of the Administrative Hearing for review of claims denied and upheld in discussion review by Discovery
  - Providers have 20 calendar days to request an appeal from the receipt of the notice
  - Instructions for requesting an appeal with an administrative law judge will be included in the final findings letter to the provider

- Final outcome
  - After the appeal period, should the administrative judge reverse the Discovery improper payment finding, the audit is closed and no action is required from the provider
  - After the appeal period, should the administrative judge uphold the Discovery improper payment finding, MSDOM will offset the improper payment against future payments to the provider

Contact information

Discovery's Provider Communications Department

- Phone: 866.880.0608
- Fax: 888.904.8842
- Email: MSDOMRecoveryAudit@discoveryhealthpartners.com

- Mail:

  Discovery Health Partners
  Attn: MSDOM Recovery Audit
  32 West 200 South #503
  Salt Lake City, UT 84101

> Discovery provides a toll-free customer service number in all correspondence to the providers
> Business hours of the Customer Service Center are from 8:00am to 4:30pm Central Standard Time
> Discovery customer service representatives are knowledgeable of the MSDOM Recovery Audit Program
> Discovery notifies all callers that the call may be monitored for quality assurance purposes

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Questions?


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