

SCDHHS Provider Outreach and Education

Recovery Audit Contractor Program (RAC)

Agenda

- SCDHHS Recovery Audit Contractor (RAC) Program Summary
- Audit Process
- RAC Complex and Automated Scope
- Review Process
- Provider Resources



SCDHHS RAC

Complex Review / Automated Summary





RAC Goals and Objectives



What is the RAC Program?

Pursuant to Section [42 CFR 455 Subpart F](#) of the Federal Code of Regulations, each state Medicaid agency must contract with a contingency-fee-based vendor to review provider claims paid with Medicaid funds. The purpose of the review is to reduce improper Medicaid payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments.



What is the goal of the Review?

The goal of the review is to reduce improper payments while also presenting billing education opportunities to providers to improve the accuracy of claims submitted to SCDHHS for reimbursement.



Collaboration and Communication

It is necessary to ensure providers understand their role in the program and know how to contact SCDHHS and HMS for questions and support.

HMS Summary

About HMS

HMS, a **Gainwell Technologies Company**, has partnered with SCDHHS to reduce improper payment while also presenting billing opportunities to providers to improve the accuracy of claims submitted for reimbursement.

Summary

- ✔ Provider of **technology-enabled, mission-critical**, IP-based software and services solutions designed to efficiently support State and Local Medicaid programs and other initiatives
- ✔ Medicaid **industry leader** with a strong reputation of service excellence, advanced software development, and **extensive industry/state specific expertise** on strategic implementations and ongoing service

Key Solution Areas Include

- ✔ Analytics
- ✔ Medicaid Management
- ✔ Cost Containment & Care Quality
- ✔ Pharmacy Solutions
- ✔ Human Services & Public Health
- ✔ Systems Integration and Interoperability

#1 Provider of Medicaid Services	
51 U.S. states and territories are clients	~25 years Average relationship length
100% MMIS customer renewal rate over the last 10+ years	5-10 years Typical duration of contracts
~60M Medicaid beneficiaries supported	11,500+ Employees
3.7M Providers served annually	1B Claims processed annually

Scope and Review Process



RAC Review Scope

What types of reviews will HMS perform?



Complex Review

Identifies improper coding, location/level of service and reimbursement errors by reviewing medical records and other clinical documentation

Example

- **DRG Clinical and Coding Validation**



Automated

Data-driven reviews identifying improperly billed, coded or paid claims according to regulatory, policy and contractual requirements and industry rules

Example

- **Duplicate**



Lookback Period: 3 years from the beginning date of service of the claim.

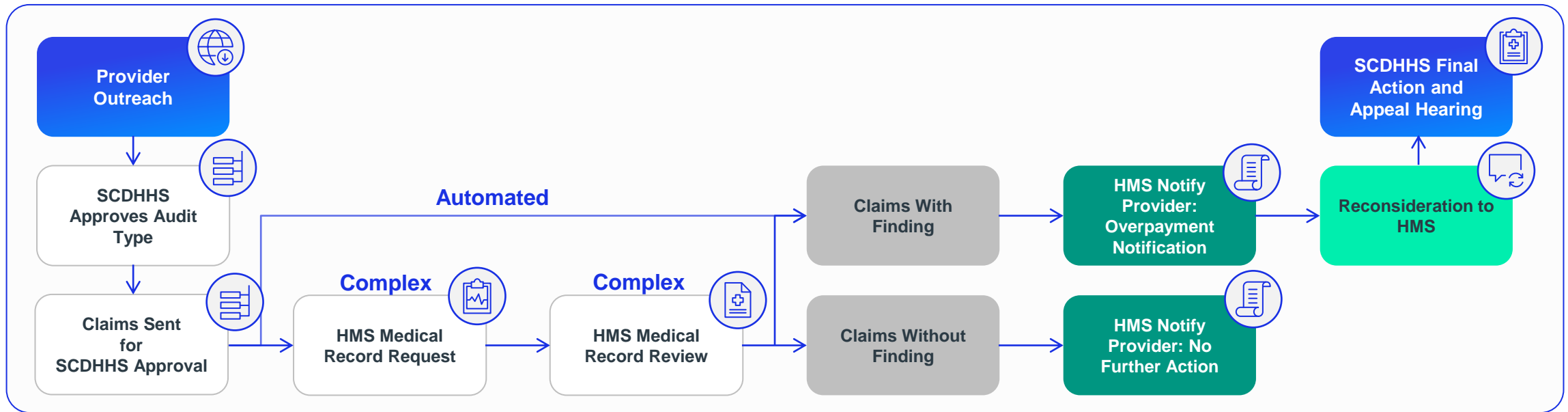


A lookback period is defined as a threshold applied to the claim data specifying how far back a review can occur.



Claim Types: All claim and provider types are subject to review under the program. The scope of the audit is reviewed and approved by SCDHHS prior to HMS conducting audit.

Overview of Review Process



Review Process

- ✓ Medical record request serves as notification of review.
- ✓ Providers will have 60 days to submit a medical record. A Follow-up Medical Record Request Letter will be mailed if not received within the time frame allowing the provider another 30 days to submit records.
- ✓ Medical records are reviewed by HMS.
- ✓ Preliminary Finding Notification will be mailed to provider with Reconsideration instruction for submission to HMS.
- ✓ Reconsideration Uphold Notification will be mailed to provider with Appeal Hearing instruction to Division of Appeals and Hearings SC Department of Health and Human Services
- ✓ Once the Reconsideration time frame has exhausted, SCDHHS will adjust the payment(s) accordingly and recoup via offset

Medical Record Requests

Medical Record Requests

**You will receive
a notification letter**

- If your facility is chosen for a review, a letter will be mailed informing you of the upcoming review. SCDHHS will determine mailing limitations to all medical record requests.
- Medical Record Request letters will be sent via USPS Mail to the address provided by SCDHHS.
- Please ensure your address is correct or up to date with SCDHHS.

**Instructions
are included**

- The letter will include instructions for submitting the medical records, the list of claims to be reviewed, and the number of days you have in which to submit documentation.

**HMS protects your
data, including PHI**

- HMS protects the data provided using the highest security standards in the industry.



For questions about how to submit records electronically, please contact **GoGreen@gainwelltechnologies.com**



If the medical record is not received within the requested time, HMS will mail a Follow Up Medical Record Request Letter.



A dedicated HMS Provider Services toll-free number is available for any inquiries:

866-376-2319



Submitting Medical Records

Electronic Method



Sending files electronically is the fastest, most convenient and preferred method

- Self register for an HMS Provider Portal account at: <https://hmsportal.hms.com>
- To set up an SFTP connection, email us at GoGreen@gainwelltechnologies.com
- Data is sent via secure file transfer protocol (SFTP) or through the Provider Portal – both methods are secure



Medical record documentation should include:

- Legible documents with good quality images.
- The complete medical record to support the services provided and billed for the dates of service requested.
 - Examples include, but are not limited to: Physician Orders, Physician Progress Notes, Discharge Summary, History and Physical, Operative Reports, Consultations, Diagnostic Results, UB04, etc.
 - Please note: Missing or incomplete medical record submission may result in a technical denial.

Place of Service (POS) Review



Place of Service Review



The POS review verifies that the place of service billed was consistent with the patient's condition and the care and services provided, as documented in the medical record.



We are performing a review of the medical record to validate that the level of care matches the clinical documentation.



This is not a medical necessity determination of services.



The review results ensure payments are consistent with the services provided.



If HMS finds an inpatient stay billed in error, in most cases the provider can rebill the claim for the level of care and services associated with the appropriate setting.



Guidelines and Criteria

- ✔ HMS can review targeted claims to verify that inpatient level of care was billed appropriately according to State and Federal regulations.
- ✔ The reviewer will use **InterQual** criteria and clinical review judgement to review the medical record and determine whether the claim has been billed consistent with the care delivered. Specifically, the reviewer will determine whether the patient's conditions and the care provided required an inpatient hospital level of care or if the care could have been safely delivered and is routinely provided in a more cost effective level of care or location.
- ✔ The HMS physician team develops proprietary job aids using current literature and standards of care to direct the review activities, provide oversight of the quality and Reconsideration programs and be available to assist reviewers in their case reviews as needed.

DRG Clinical and Coding Validation



DRG Clinical and Coding Validation



HMS Reviews Targeted DRG Claims

HMS verifies that all diagnoses and procedure codes were billed appropriately in accordance with ICD 10-CM Official Guidelines for Coding and Reporting and are consistent with the documentation in the medical record, resulting in accurate DRG assignment and reimbursement.



DRG Coding Validation

Coding validation is the process of verifying that codes were billed and sequenced in accordance with coding guidelines.



DRG Clinical Validation

Clinical validation verifies diagnoses coded were present based on the clinical documentation in the medical record, and the results of related diagnostic testing were consistent with the diagnoses.

DRG Clinical and Coding Validation Elements



Validate the principal and secondary diagnoses to ensure all diagnoses were billed appropriately, supported in the medical record and billed according to official coding guidelines.



Validate that clinical documentation and results of diagnostic testing support the billed diagnosis.



Validate all procedure codes to ensure they were coded accurately according to official coding guidelines and are supported by the documentation in the medical record.



Verify the discharge status code and all other data elements affecting the DRG assignment.



Verify diagnoses identified as Hospital-Acquired Conditions were coded with the correct Present On Admission indicator.



Guidelines and Criteria

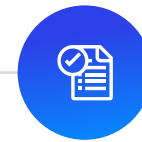
HMS uses nationally recognized criteria and industry standard guidelines for establishing diagnoses.



ICD 10-CM
Official
Guidelines for
Coding and
Reporting



Industry standard criteria
and definitions to
substantiate the billed
diagnoses codes affecting
DRG assignment



Criteria that are generally
accepted by the medical
community from professional
guidelines and other
evidence-based sources

Automated



Automated

Identifies claims improperly billed, coded, or paid according to regulatory, policy, contractual and industry rules



HMS executes proprietary rules engine against paid claim data to identify improper payments.



Medical record is not required to determine an inappropriate payment – identification occurs by comparing rules to claim data elements.



HMS proprietary rules engine is configured with rules customized to SCDHHS specific policy and direction.



SCDHHS approves each improper payment type prior to any audit activity is initiated.

The findings from this analysis are reported to SCDHHS.

Clinical Review Process





Review Process

After we receive the requested medical records, one of our experienced clinical reviewers will perform an in-depth review of the submitted documentation.



HMS reviews the claim and submitted documentation to validate that the setting, services and billing are consistent with the documentation.



Reviews are conducted by nurse reviewers, certified coders and clinical auditors under the direction of HMS medical directors.



HMS's quality program ensures determinations are accurate and consistent with guidelines.



The turnaround time is dependent on our contract agreement with SCDHHS.

The medical record review results are reported to SCDHHS, along with payment decision outcomes.

Improper Payment Notifications and Reconsideration



Determination Notification



Based on the findings of the review, a determination notice is sent to the provider with the results.



If the notice is the result of a Complex finding of inaccurate billing, HMS provides detailed clinical rationale to support the determination.



It's possible you may disagree with the review findings and rationale. We include detailed instructions for requesting a reconsideration to HMS in the notice you receive.

Preliminary Finding Notification

Preliminary Finding Notification Letter

- ✓ Indicates that a claim review resulted in an improper payment and provides reconsideration instructions to HMS.
- ✓ The notification letter is comprised of:

01. Cover letter

- Instructions for requesting:
 - Reconsideration request in writing
 - Request must be received within 60 days of the notification

02. Audit Detail

- A listing of all claims reviewed and determined to have an improper payment.
- For each claim, the audit detail will provide the rationale for the improper payment.

- ✓ If a medical record review was performed and resulted in no improper payment determination, the provider will receive a No Further Action Required Letter



Reconsideration Process



Reconsideration request to HMS in writing within 60 calendar days of notification of improper payment.

A concentrated effort is made to assure that finding letters are detailed and specific, helping reduce the burden of Reconsiderations on all parties.

HMS will provide the outcome of the reconsideration review in writing via the Reconsideration Uphold or Overturn letter.

Reconsideration Response Letters

Reconsideration Exhaust Letter

- ✔ Notification of late Reconsideration request submission

Reconsideration Overturn Letter

- ✔ Review of additional documentation identifies no findings of improper payment
- ✔ No further action needed

Reconsideration Uphold Letter

- ✔ Review of additional documentation concludes that initial determination was accurate
- ✔ Provides Appeal Hearing instruction to Division of Appeals and Hearings SC Department of Health and Human Services within 30 calendar days of the Reconsideration Uphold Letter



Final Finding Notification

Final Finding Notification Letter

- ✓ Provides an additional 30 calendar days to submit a reconsideration to HMS if a reconsideration was not previously received
- ✓ The notification letter is comprised of:

01. Cover letter

- Instructions for requesting:
 - Reconsideration request in writing
 - Request must be received within 30 calendar days of the notification

02. Audit Detail

- A listing of all claims reviewed and determined to have an improper payment.
- For each claim, the audit detail will provide the rationale for the improper payment.



Provider Resources



Open Communication

- ✔ HMS encourages providers to contact us with their concerns and questions.
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- ✔ We view our one-to-one discussions as ideal opportunities to provide education, answer any questions and alleviate concerns.
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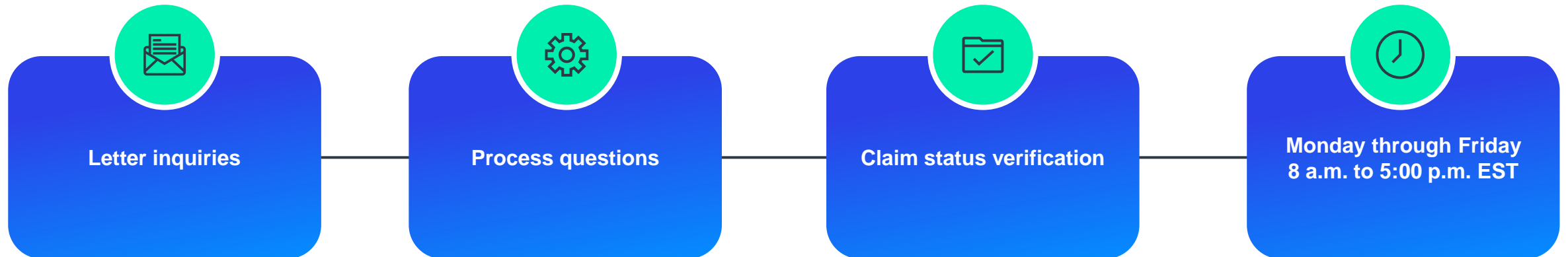
- ✔ Our Provider Relations team stands ready to guide you throughout the entire process.

Provider Support

Provider Portal site: <https://hmsportal.hms.com/>

HMS Provider Education Website: <https://resources.hms.com/state/southcarolina/rac>

HMS Provider Relations Line: **866-376-2319**



Gainwell Provider Portal

Cloud-based solution that allows providers to manage activities with HMS



Significant improvement in speed



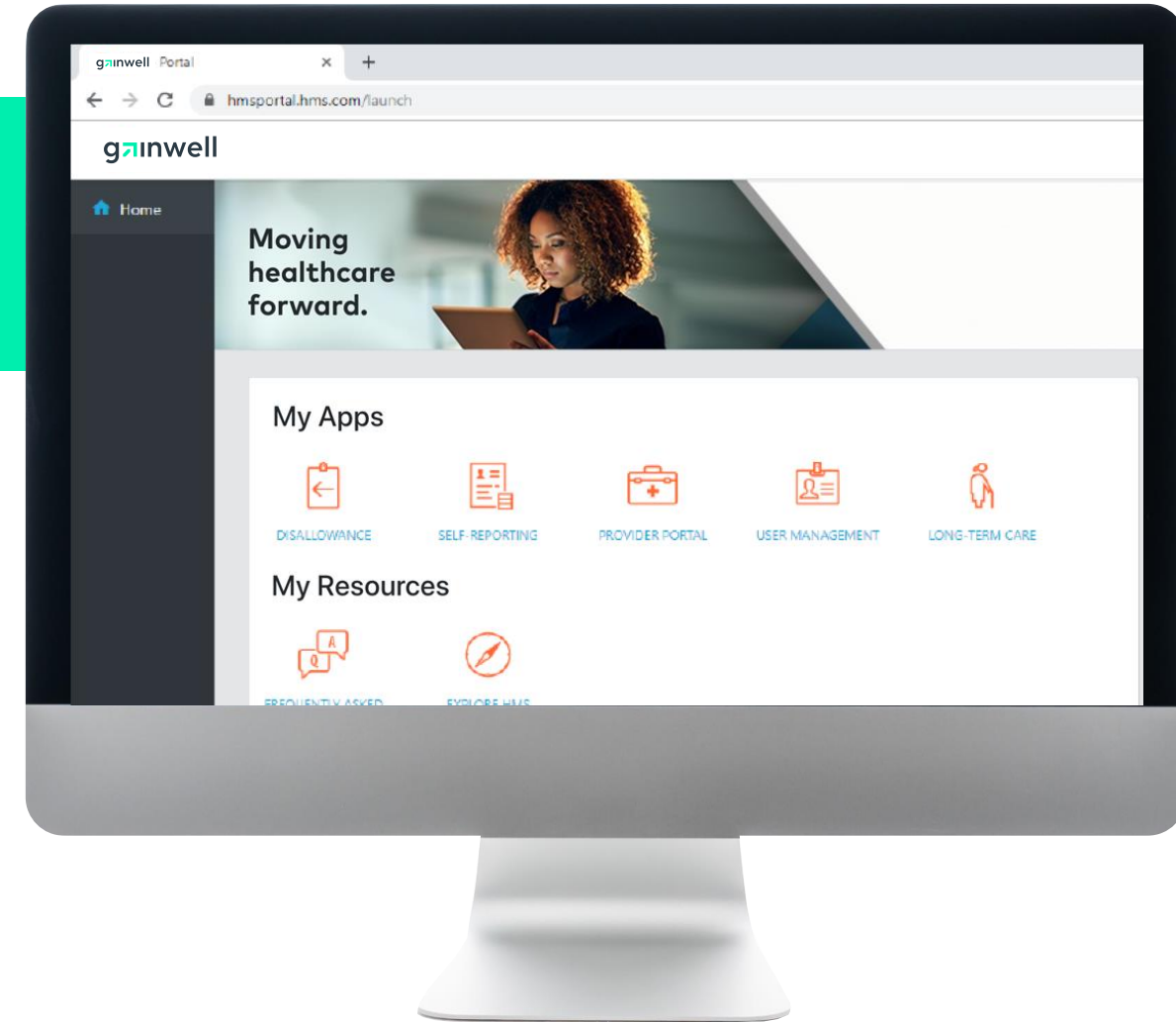
Increased quality



Reduction in costs (mailroom, paper)



Improved provider experience



Provider Portal Features and Capabilities


Portal Features

- Near real time (24 hour) claim status updates with HMS PI Platform (medical record receipt, review result, reconsideration status, letters)
- 24/7 access to claim status information
- Dashboard View providing status of all historical and current claims in audit
- HMS Provider Services support for ongoing education, user registration, and inquiry resolution
- HMS HelpDesk support with Portal user access issues (i.e. lockout)
- Detailed User Guide available in Portal (step by step instruction)
- On demand training videos

Provider Capabilities

- Locate medical record requests
- Upload of medical records documentation
- Submit a reconsideration
- View, print, and obtain copies of HMS Letters
- Verify status of claim
- Update provider address and POC for HMS letters
- My Workload Queue reflecting all claims outstanding requiring provider action
- Claim Export Status Report

Education and Outreach

Format	Purpose	Method	Contact Initiator	Recipient
 Provider Notification	Provide advance notice of audit activities and provider webinars	SCDHHS Website	SCDHHS	Provider
 HMS Provider Website	Provide an overview of the audit, review process, FAQs, and notable links	Web-based	HMS	Provider
 Provider Webinar	Provide an overview of the audit and review process	Web-based	SCDHHS HMS	Provider
 Telephone Calls / Email	Answer inquiries related to audit process, claims status, medical documentation receipt, HMS provider portal	Telephone Email	HMS	Provider
 HMS Provider Portal	Allows providers to manage medical records with HMS: submission, audit, findings letters, and rebuttals	Web-based	HMS	Provider

Q & A

An abstract geometric composition featuring various teal and dark teal shapes. The design includes several rectangles and parallelograms, some of which are nested or overlapping. A prominent feature is a large, dark teal parallelogram in the center, surrounded by other shapes of varying sizes and orientations. The background is a solid dark teal color, and the shapes are rendered in different shades of teal, creating a layered effect.

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