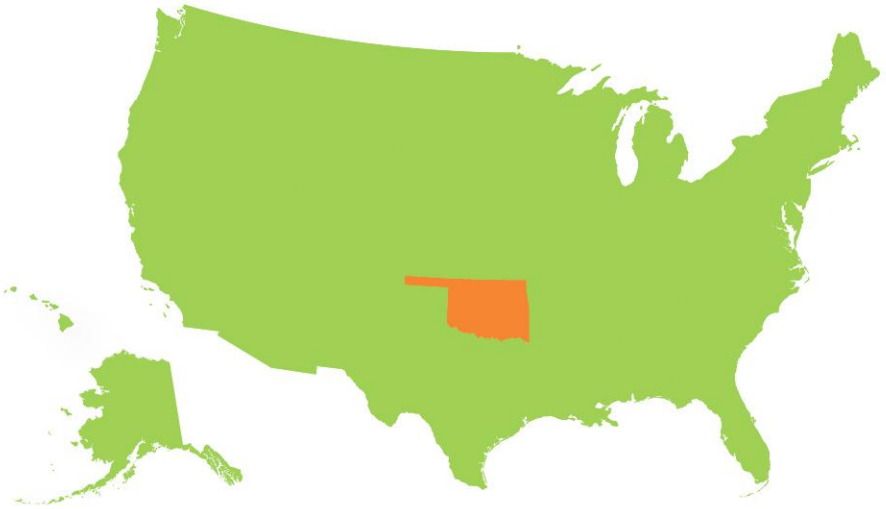
Oklahoma Health Care Authority

Recovery Audit Contract
Provider Outreach & Education Presentation

October 22, 2013



Agenda

- Introductions
- HMS Overview
- Medicaid RAC Review Process
- Provider Outreach & Education
- Audit Selection Process
- Medical Records Requests
- Provider Portal
- Credit Balance Audit Overview
- Key Contacts and Resources

About HMS

- We provide cost containment services for healthcare payers
- We help ensure that claims are paid correctly (program integrity) and by the responsible party (coordination of benefits)
- As a result, our clients spend more of their healthcare dollars on the people entitled to them

Background Recovery Audit Contractor

- **Medicare Modernization Act of 2003 created a demonstration project to identify Medicare overpayments**
  - The program was operational from 2005 through 2007
  - Following success of the demonstration project, the program was made permanent in 2008

- **Section 6411(a) of the Affordable Care Act expanded RAC to Medicaid and required each state to begin implementation by January 1, 2012**
  - Identification of overpayments and underpayments
  - State & RAC vendor must coordinate recovery audit efforts
  - RAC vendors reimbursed through contingency model

HMS-Medicaid RAC Standards

Reduce provider abrasion, provide education, customer service and limit administrative costs.

Possess in depth knowledge of OHCA Medicaid policies, regulations and MMIS processes.

Maintain an understanding of the state's operating environment – political, provider associations, agency goals.

Experienced in coordinating with other state audit entities.

Have established processes for a) Receiving and Formatting Medicaid Data, b) proven provider relations and c) seamless recovery function.

Overview of Review Process

Analysis And Targeting

- Program Analysis
- Data Mining/Scenario Design
- State Approval

Record Request

- Provider Contact
- Record Request/Receipt
- Tracking/follow up

Review/Audit

- RN/Coder Review
- Physician Referral
- QA and Client Review/Approval

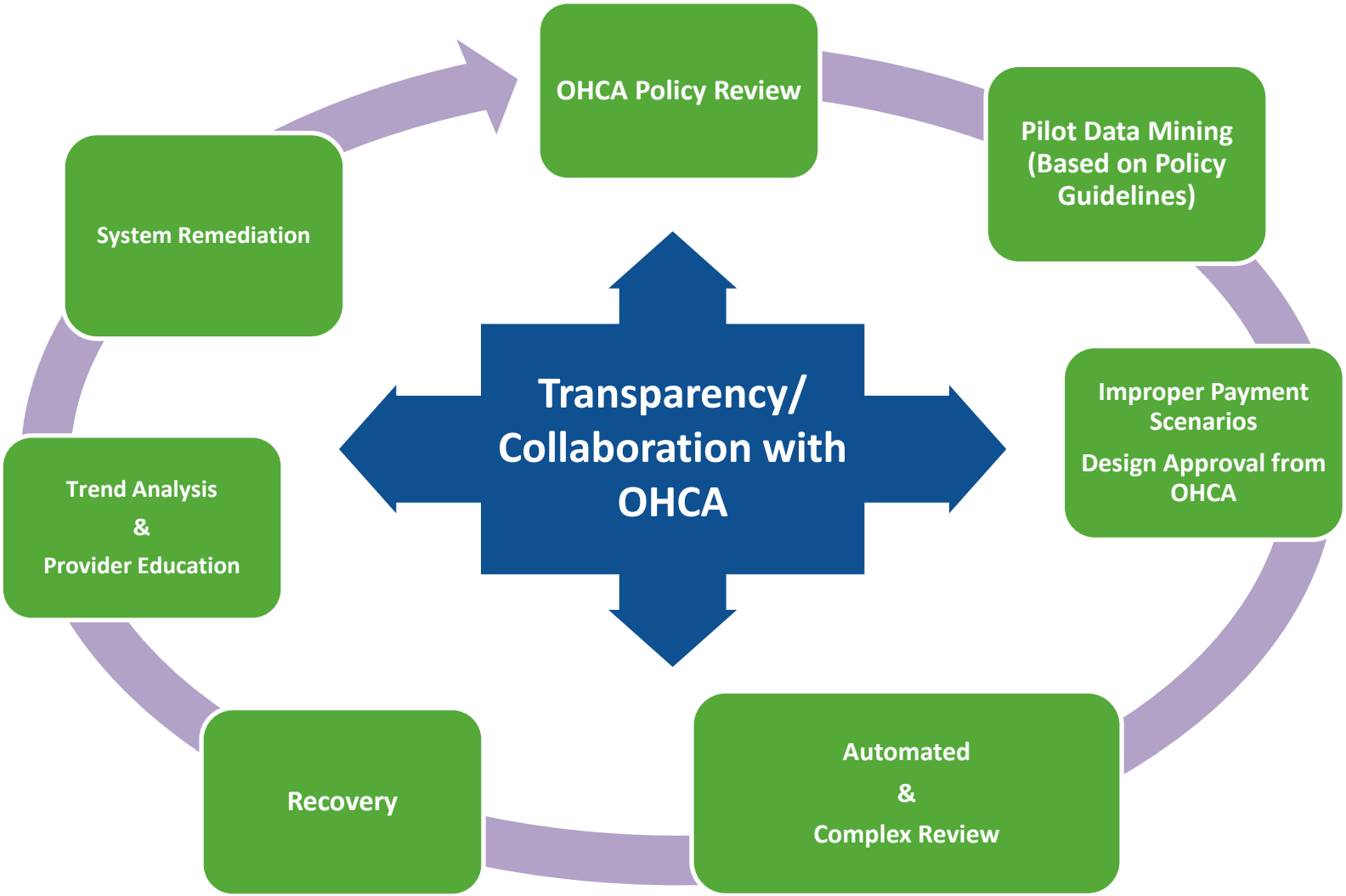
Notification and Recovery

- Notification Letter
- Reconsideration/Appeal
- Recovery Support

Education, Process Improvement

- Provider Association Meetings
- Program Recommendations
- Newsletter/Website

RAC Process: Flow



Key RAC Considerations and Audit Selection Process

- **Diverse focus on multiple provider and claim types**
- **OHCA approval on all initiatives**
- **Pilot approach to confirm issue/scenario**
- **Comprehensive provider education**
- **Supplement and wrap around existing OHCA efforts**
- **360 degree claim review**
  - Clinical
  - Regulatory
  - Billing
- **Comprehensive panel of experts**
  - Physicians, Nurses, Coders
  - Data Analysts
  - Financial Auditors

HMS RAC Support Staff

- **Experienced staff performing reviews according to provider types included in contract:**
  - Certified Coders
  - Registered Nurses
  - Auditors (CFE)
  - Dental Hygienist/Dentist
  - Medicaid billing experts
  - Specialized Therapy Professionals
  - Review Panel of over 1,000 Physicians

- **HMS has in-depth knowledge of**
  - OHCA Medicaid billing & reimbursement practices
  - Claims adjudication process
  - Data processed by OHCA MMIS

Types of Reviews - Automated

- **Automated Review is applied in scenarios where improper payments can be identified clearly and unambiguously.**

1. The Initial Recovery Letter is generated notifying providers of:
   - Payment error
   - Related policy rule/criteria/regulation
   - Amount of improper payment
2. Providers request an informal reconsideration and provide additional information.
3. As applicable, HMS reviews any additional information, and re-evaluates whether an improper payment exists based on OHCA Medicaid policy.
4. After the re-evaluation process the result letters are sent to providers. The letter communicates:
   - Detailed description of final determinations
   - Improper payment amount
   - Option to appeal

Types of Reviews - Complex

- **Complex Review is required when analysis identifies a potential improper payment that cannot be automatically validated.**

1. Claims are flagged for further review and HMS determines what documentation is required to determine if an improper payment exists and/or the amount of the improper payment

2. Documentation is requested from the provider or appropriate party and reviewed to determine if an improper payment exists

3. After the review process is completed, result letters are sent to providers. The letters communicate:
   - Detailed description of final determinations
   - Improper payment amount
   - Option to appeal

Review Process timelines, Scope , & Medical Records Requests

- **Look back period- up to 30 months from date claim was paid**
- **Scope: Medical, Dental, RX, DME, and Credit Balance**
- **Current exclusions:**
  - Tribal Services
- **If an automated or complex disallowance review letter is issued, providers have 20 days to respond to the letter from the date of receipt**
- **Initial records request: Record requests are due to HMS by the end of the 20th business day from receipt of the letter documented by standard postal delivery tracking methods**
- **Failure to comply will result in the determination that your agency was improperly paid for all services under review for the requested dates of service, resulting in a pay hold being placed**

OHCA's Medicaid RAC Program

HMS, as the Recovery Audit Contractor (RAC), audit areas

	Credit Balance Financial Audits	Clinical Complex Reviews	Automated Reviews
Provider Types Approved to Date	Acute Care Hospitals	All Provider Types	ALL Provider Types
Medical Record Limits	Not applicable- Financial Audit only	Yes - OHCA will set by Provider Type as audits are approved * Note: OHCA may authorize exception on a case-by-case basis.	Not Applicable
Type of Audit	On-site or desk reviews	Desk reviews	Desk reviews
Audit Notification	HMS letterhead	OHCA letterhead	OHCA letterhead
Types of Records	• Aged Trial Balance/ATB •Credit Balance Report •Debit adjustment reports • Other claim documentation	• Medical records • Varies by audit For example: ✓Discharge summary ✓Physician orders ✓Labs, x-rays ✓Medication Records	• Medical records • Varies by audit

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OHCAs Medicaid RAC Program

Additional comparisons by audit area

	Credit Balance Financial Audits	Clinical Complex Reviews	Automated Reviews
Who to Contact?	Assigned Auditor	Provider Services	Provider Services
Source of Audits and Frequency	All acute care hospitals: variable based on audit results	Data mining and algorithms: variable based on audit results	Data mining and algorithms: variable based on audit results
Claim Selection	Claim-by-claim	Varies per audit	Varies per audit May use sampling in the future.
Entrance Conference	Yes on-site or by conference call	No, but provider may contact HMS Provider Services anytime	No, but provider may contact HMS Provider Services anytime
Exit Conference	Yes on-site or by conference call to review worksheets	No, but provider may contact HMS Provider Services anytime	No, but provider may contact HMS Provider Services anytime

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Review Process Information

- **Current OHCA appeal process will be utilized**
- **Concentrated effort made to assure that audit letters are detailed and specific, helping reduce the burden of appeal on all parties**
- **Providers are encouraged to call HMS' Provider Services to discuss and resolve issues**
  - OHCA RAC toll free number: 855-474-5113
  - Email: to be established
  - Web site: coming soon
- **Call volumes are monitored to address potential issues which may be used in educational sessions**

HMS RAC Website for Providers

Medicaid RACs
a service of hms

Legislation | State Activity | Considerations | FAQ | Resources | For Providers | Contact HMS | Blog

Not All Medicaid RACs Are Alike

One provision of the Affordable Care Act requires state Medicaid agencies to contract with a Recovery Audit Contractor (RAC) to identify and recover Medicaid overpayments and underpayments. While these audits may be necessary, they shouldn't interfere with your primary goal of caring for your patients.

HMS has been working with Medicaid providers since 1985. As an experienced vendor in Medicaid overpayment recovery, we understand the potential burden these audits can cause for providers. Our emphasis is on making the process easy for you, so you can stay in compliance while focusing on your real job.

Here's our "Top Six" list of what you should expect from any RAC contractor — and why HMS delivers with a difference:

1. A full understanding of every aspect of the audit process — right from the start. We conduct face-to-face meetings and conference calls with hospitals and provider associations, and individual providers. We work with multiple contacts at your facility to make sure that everyone has a common understanding of the process and objectives.
2. A 24/7 state-of-the-art web-based portal to help you navigate the overpayment identification and recovery process — without the burden of paper. Through our Provider Portal, claims targeted for potential overpayments are delivered electronically, and can be accessed at your convenience. You can also respond to requests, submit questions, update contact information, and more. Our Portal also simplifies the self-disclosure process. Today, over 26,000 providers use our Provider Portal to help them manage the audit process.
3. A full-time Provider Services team to guide you through the audit process. Our team is focused exclusively on responding to your inquiries, and has the experience required to promptly and accurately respond to your questions regarding the review and recovery process. Our Call Center handles approximately 23,000 calls every month, and we accommodate time zones across the country.

   Your medical records and other documents are safe with HMS. When you send them to us, they do directly into our content imaging system, where they are highly secured and ready for prompt processing.
4. Regular updates on findings. We regularly participate in state hospital and provider association meetings and publish information about trends and issues identified on our website. We also publish quarterly newsletters and conduct webinars to keep you up to date.
5. A highly skilled Clinical Review team. Registered nurses, certified coding professionals, and physicians experienced in the review of medical records work together to review claims and make fair determinations based on your state's policy and regulations. Our audit expertise crosses all Medicaid service types, including hospital, long term care, pharmacy, DME, and behavioral health.

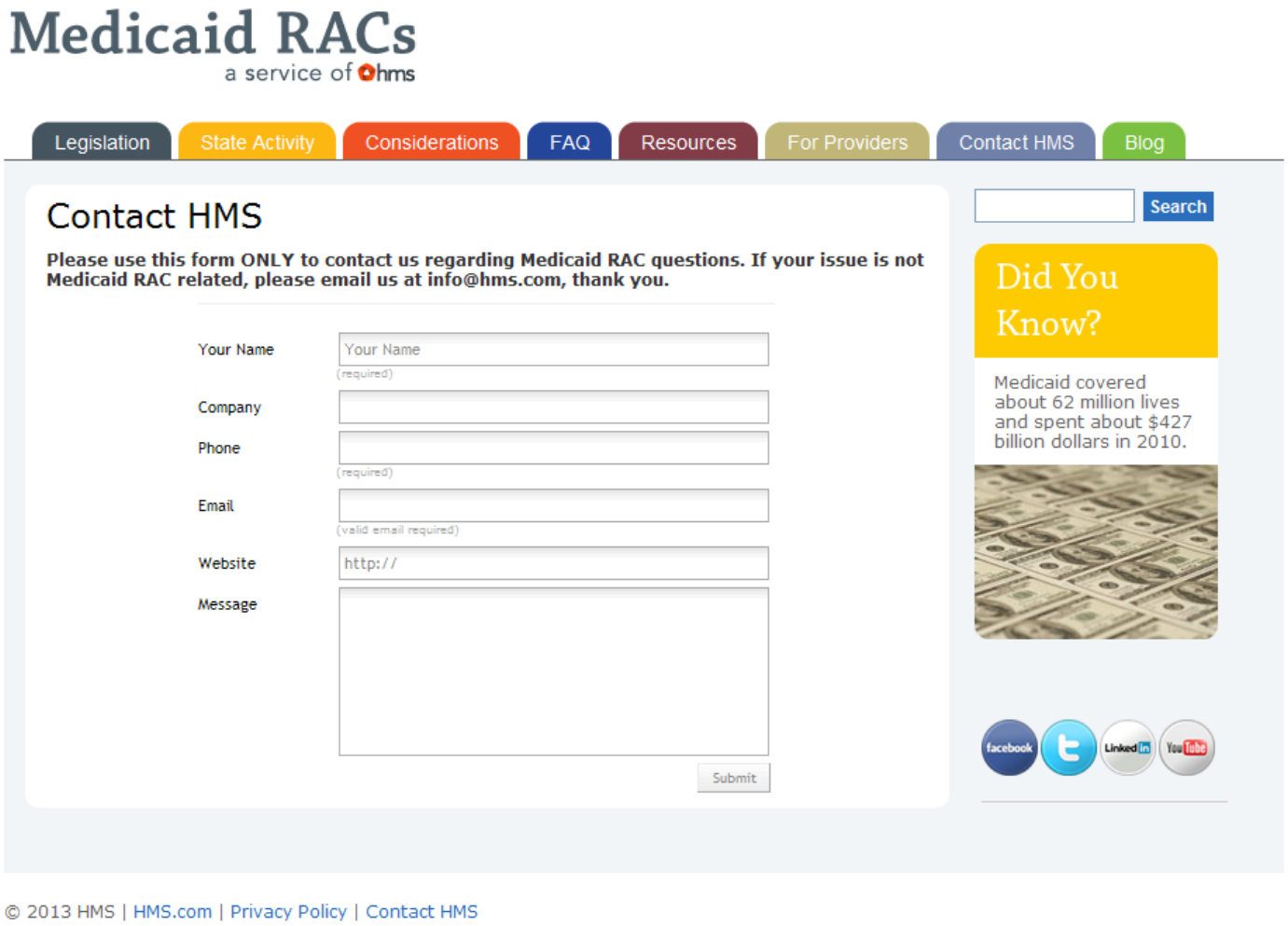
Search

Did You Know?

CMS is projecting a 40% increase in Medicaid lives from 2010 to 2015.

Provider Comments on Draft Medicaid RAC Rules & CMS Response

HMS RAC Website Contact HMS



HMS Audit Support

HMS Provider Services' staff are practiced at establishing and maintaining effective communication with providers and strive to resolve provider issues on the first call

Focused Provider Relations

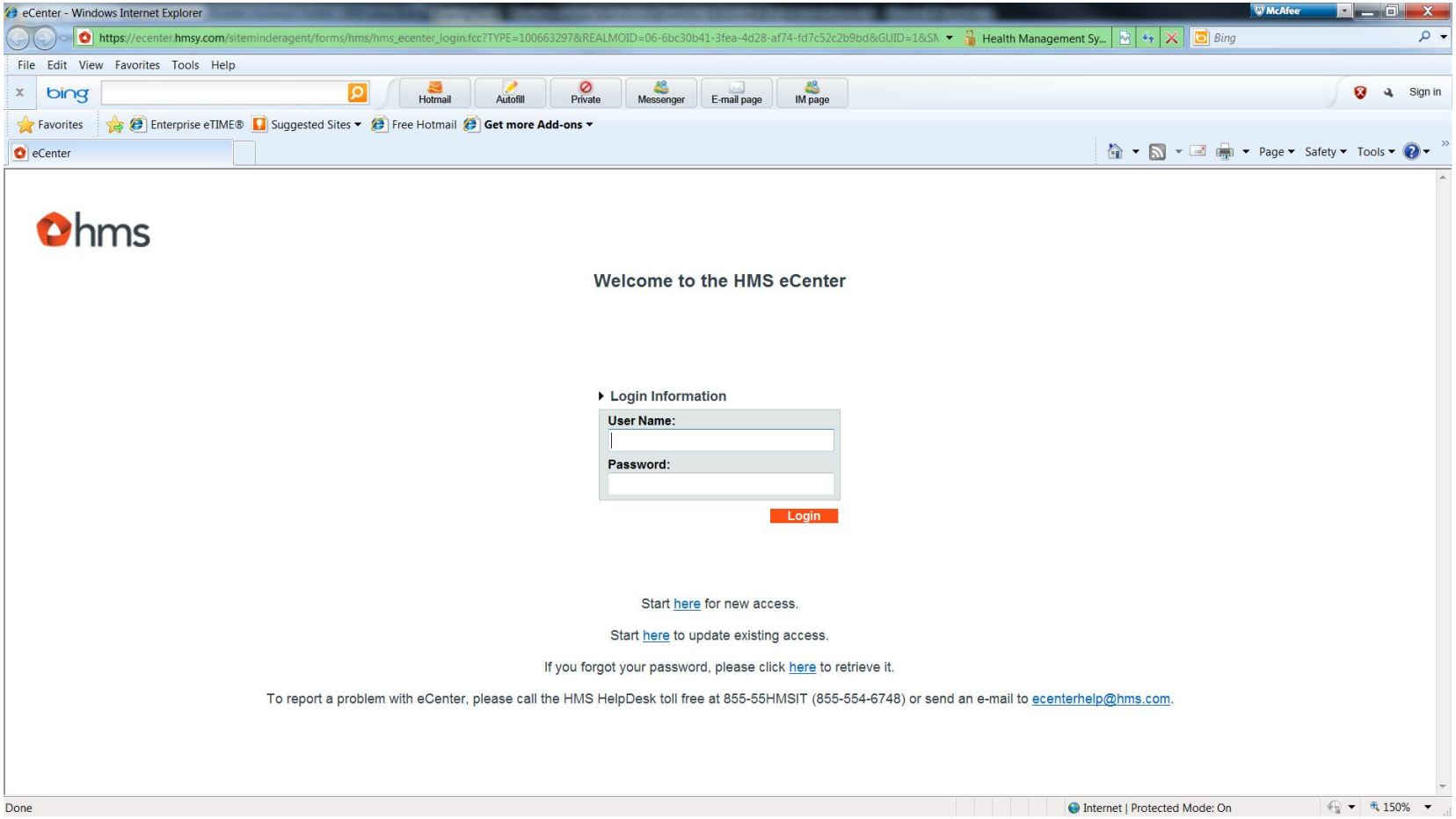
- **Outreach**
  - Attend provider association meetings
  - Develop appropriate communication through webinars, HMS RAC website, and newsletters
- **Transparency**
  - Schedule of events and upcoming audits
  - Broadcast modifications to process
- **Education**
  - HMS staff available to assist with issue resolution

Provider Portal Overview

- The Provider Portal is a secure website that allows providers manage their RAC reviews
- More than 15,000 providers currently use HMS's Provider Portal
- Contact information can be updated by providers
- Contains HMS contacts

Provider Portal

Secure website for each provider to manage reviews



Who is HMS CBA?

- Currently serves 24 State Medicaid agencies, many Medicaid Managed Care Organizations (MCO) and State Health Benefit Plans
- 14 years of experience working with providers on credit balance audit projects
- Credit Balance Staff dedicated specifically to financial reimbursement reviews
- Experience determining and communicating the root cause of the identified overpayments or accounts resulting in credit balances

What is a Credit Balance?

- **A credit balance occurs when the sum of payments received plus adjustments exceed the total charges on a claim**

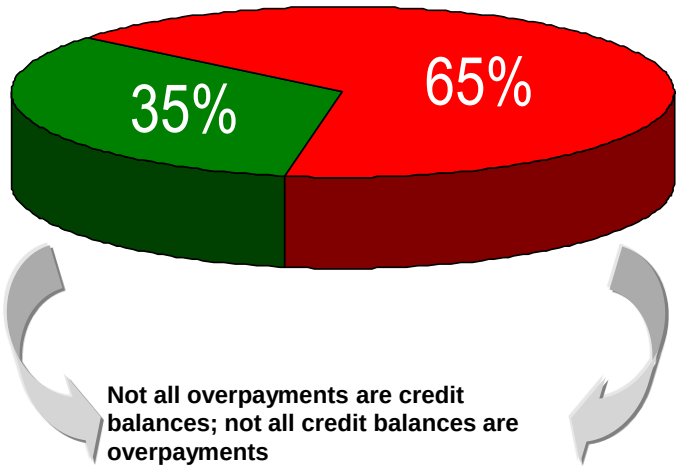
- **Common causes of credit balance include:**
  - Payments from third party payors and from Medicaid
  - Duplicate Medicaid payments
  - Charge reversals/adjustments/transfers
  - Duplicate adjustments made in the provider's system

Approach

ROOT CAUSES

MONETARY

- COB
- Retroactive payments
- Double payments
- Incorrect payments



NON-MONETARY

- Inaccurate postings
- Charges written off in excess of amounts actually billed
- Provider A/R collection systems modeling net revenue at the time of billing

HMS approach leverages multiple processes to identify all overpayments

What to expect

- 30 days prior to the audit the Provider will receive written notification of the audit start date
- Prior to the On-Site review HMS will request selected documentation
- Once HMS receives the requested documentation from the provider it will be determined if an on-site review or a desk review is warranted.
- The On-Site audit will last for 2 – 5 days depending on the volume of accounts to be reviewed
- Once the audit has been completed the provider will receive a credit balance worksheet along with all supporting documentation for each refund identified
- OHCA will offset recovers following the exit interview for the audit

Prior to On-Site Audits

In order to expedite the on-site review process, HMS requires that certain documents and information be provided one week prior to the scheduled on-site date. Below is the list of information that must be provided:

- A detailed listing of all Medicaid accounts in a credit balance status. The list should include all accounts in which Medicaid has made any payments (primary; secondary; tertiary) – regardless of the current financial class of the account. At a minimum, the report should include the patient name or account number and the credit balance amount. The timeframe for this report is the last closed fiscal month or the most current report available. Timeframe unclear use dates of service
- Provider's credit balance policies and procedures.
- List of all subcontractors who bill Medicaid on behalf of the provider (if applicable). For example, the names of vendors who bill Medicaid for specific clinics or patient types should be included.
- Name of Patient Accounting Billing systems used to bill Oklahoma Medicaid Program (e.g., Meditech, SMS, etc.).

On Site

The on-site review consists of the following:

- Credit Balance Reconciliation: HMS will review claims identified on the credit balance listing report to determine if any Medicaid overpayment exists. If an overpayment is identified, HMS will document the overpayment utilizing Medicaid RAs, EOBs and, as necessary, account detail information from the patient accounting system.

- Reconciliation of Credit Balance Listing Report: HMS will review source documents and/or general ledger information to ensure the credit balance listing report includes *all* Medicaid credit balance accounts.

- Unposted Cash: HMS will review posting processes to ensure all Medicaid payments have been either posted to the correct claim or returned to Medicaid.

On Site – cont.

The on-site review consists of the following:

- Check Reimbursement: If the provider has refunded overpayments to Medicaid via check, HMS will sample the refund checks to ensure they have been received and processed by Medicaid.

- While on-site, HMS will need access to the following: patient accounting system; Medicaid RAs; EOBs; and appropriate staff to answer questions about specific accounts or processes.

End of Review – Sample Report

Credit Balance Worksheet

hms

Provider ID: 12345
Provider Name: ABC Hospital
Auditor: Pamela Williams
Audit # PWIL-082913-001
Client: Demo Commercial

Audit Begin Date: 8/29/2013

Patient Name			Account Number	Recip ID
Smith, John			9876543	FSH309M90790
Dates of Service	**Claim Type**		**Claim #**	
3/21/2012 - 3/30/2012	INPATIENT HOSPITAL		20124567890	
Total Charges	**Provider Total Charges**	**Refund Amount**	**Reason**	
$52,008.00	$52,008.00	**$30,132.47**	Change in provider billing	
Check Number	**Check Amount**		**Client Payments**	**Client Adjustments**
			$38,046.16	$11,961.84
Recoup Request Date	**Recoupment Date**		**Recoupment Amt**	**Payments + Adjustments**
				$50,008.00

Payment History

Primary Anthem BCBS of OH — Sub Name: Betty Smith — Relation to Pt: Parent
Policy # FSH309M90790 — Grp Name: Happy Fins — Grp # 00555990

Pymt Amt	Paid Date	Tot. Charges	Clm #	Total Adj $
$38,046.16	2012-04-23	$52,008.00	20124567890	$11,961.84

Comments

Provider issued corrected claim decreasing charges from $52,008.00 to $29,570.00 (Charges went form outpatient to inpatient). Per contract with provider effective 01/01/2012, the correct expected Anthem BCBS of OH payment is $7,913.69: $9,463.69 allowable - $1,550.00 patient liability = $7,913.69. Refund Anthem BCBS of OH $30,132.47 (clm # 20124567890).
Debit adj. $8,144.47/ Patient owes $1,500.00

Signature _____ Date _____

Please remit payment to: SAMPLE ATTENTION, PO Box, New York, NY 11111-2222

PWIL-082913-001+CBW

Credit Balance: Provider Education

- Open communication with providers throughout audit process
- Root cause analysis assists providers in preventing future overpayments
- Insure providers are up to date on the latest billing and reimbursement methods utilized by the Oklahoma Health Care Authority

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