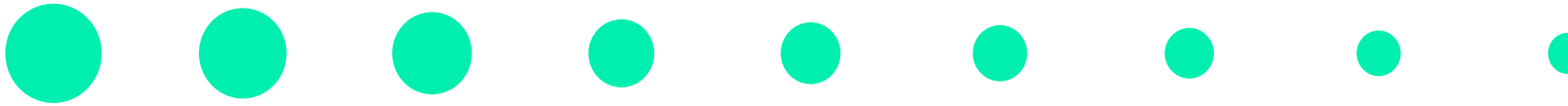
Illinois Healthcare & Family Services Recovery Audit Contractor (RAC) Program Provider Outreach and Education

Clinical Claim Review Solutions and Process



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Introduction

- Brian Dunn, Inspector General
- Lisa Castillo, Chief of the Bureau of Medicaid Integrity

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- Lauren Richardson, Program Director
- David D. Johnson M.D., Senior Medical Director
- Mary Stine, Senior Director Clinical Innovation
- Iris Roy, Manager Solution Architect

Agenda

01 IL Recovery Audit Contractor (RAC) Summary

02 Audit Process

03 Illinois RAC Scope

04 Review Process

05 Provider Relations

06 Provider Education Opportunities

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 a RAC Program?

The goal of the RAC program is to reduce improper Medicaid payments while also presenting billing education opportunities to providers to improve the accuracy of claims submitted to IL for reimbursement.

Collaboration and Communication

Ensure providers understand their role in the program and know how to contact IL and HMS for questions and support.

Purpose

01

Understanding the Review Solution

Provide an overview of the Place of Service and DRG Review Solution.

02

Understanding the Review Process

Provide an overview of our medical record request and review process.

03

Collaboration and Communication

Ensure questions and concerns are addressed and providers know how to contact Gainwell for questions and support.

About Gainwell

Summary

- Provides **technology enabled, mission critical** IP-based, software and services solutions designed to efficiently deliver State and Local Medicaid programs and other HHS 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

~20 years
Average relationship length

100%
MMIS customer renewal rate over the last 10+ years

6–10 years
Typical duration of contracts

~58M
out of 77M Medicaid beneficiaries supported

10,000+
Employees

3M
Providers served annually

1.1B
Claims processed annually

Audit Process

Overview of Audit Process

Analytics and Data Mining

- State and federal regulatory review
- State policy and contract analysis
- Scenario design or audit concept development
- Data analytics and claims identification based on policy guidelines

Record Request

- Claim or set of claims selected for review
- Medical record request
- Medical record receipt

Review and Audits

- RN, coder, pharmacist and behavioral health professionals
- Physician referral and review
- Quality assurance

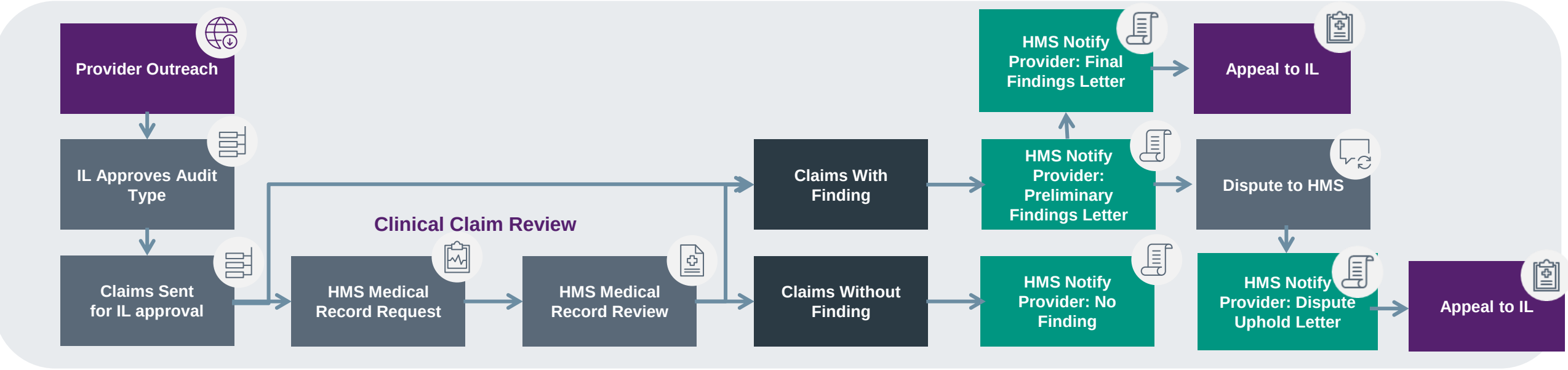
Notification and Recovery

- Preliminary and Finding determination letters
- Disputes and appeals

Education

- Provider relations and education
- Program and quality recommendations
- Info sheets and website

Overview of RAC Audit Process



Audit Process:

- Medical record requests serves as notification of audit.
- Providers will have 30 days to submit a medical record. Follow-up letter will be mailed if not received within time frame
- Medical records are reviewed by HMS
- Preliminary Finding Letter will be mailed to provider with HMS dispute instruction
- Final Findings Letter will be mailed to the provider with appeal rights to the IL Department of Healthcare and Family Services.
- If providers agree with the finding, you have the option of submitting a refund check in full, or payment in 12 installments.

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. IL will determine mailing limitations to all medical record requests

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 data provided by providers and health plans 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:

  1-855-699-6292

Submitting Medical Records

Electronic Method

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

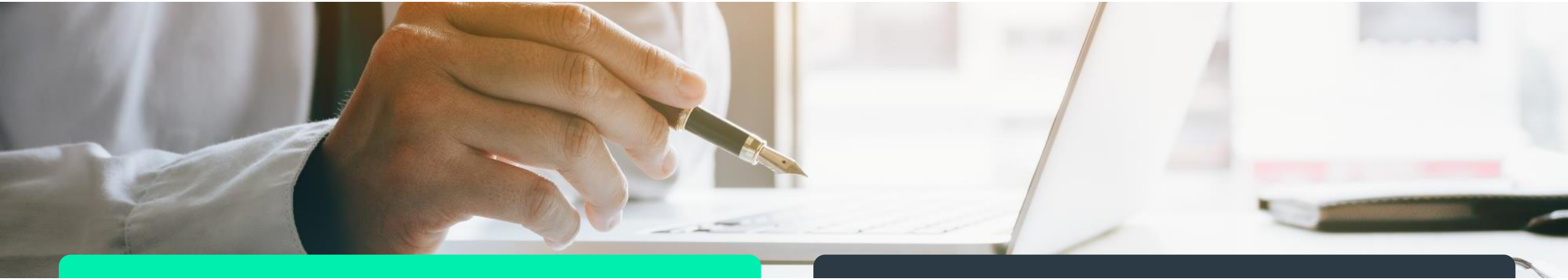
- Data is sent via secure file transfer protocol (SFTP) or through the Provider Portal – both methods are secure
- To set up an SFTP connection, email us at GoGreen@gainwelltechnologies.com
- Self Register for an HMS Provider Portal account at: https://hmsportal.hms.com

To start sending files through your new connection, keep this in mind:

- Ensure your documentation is legible with good quality image scans.
- Records should support the services provided and billed for the dates of service requested, and include items such as inpatient admission orders, physician documentation and notes, and physician orders.

Place of Service (POS) Review

Place of Service (POS) Review



The POS review verifies that the place of service billed by the provider 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

The audit results ensure payments are consistent with the services provided

This is not a medical necessity determination of services

Guidelines and Criteria

- HMS can review targeted claims to verify that inpatient level of care was billed appropriately according to State and Federal regulations. Recognizing that CMS standards are often used as payment standards across the industry, HMS works with clients to apply these standards to Medicaid (assuming there is no state mandated regulatory guidance to the contrary).

- The reviewer will use InterQual criteria and clinical review judgement (the standard specified by CMS) 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 less intensive 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 appeals programs and be available to assist reviewers in their case reviews as needed.

DRG Validation Review

DRG Clinical and Coding Validation

HMS Reviews Targeted DRG Claims

HMS verifies that all diagnoses and procedure codes were billed appropriately in accordance with 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

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.

Purpose of the DRG Validation Review

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.

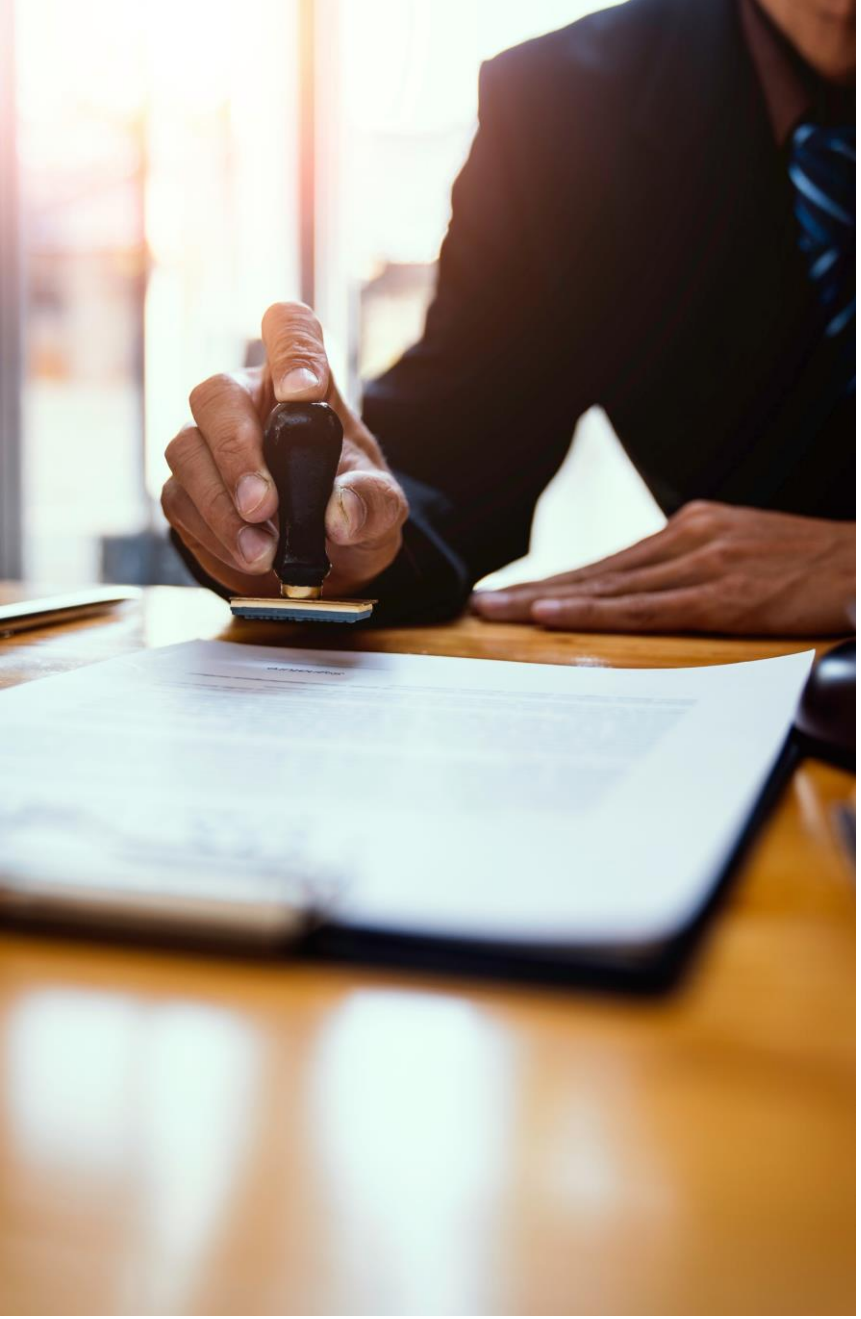
Guidelines and Criteria

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

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.



DRG Clinical Validation

Sepsis Criteria

HMS uses the Third International Consensus Definition (better known as Sepsis-3) as the evaluation criteria for payment purposes for sepsis.

This is the standard currently being used in the medical community.

Sepsis is defined as a life-threatening organ dysfunction caused by a dysregulated host response to infection. For clinical operationalization, organ dysfunction is represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 points or more, which is associated with an in-hospital mortality greater than 10%.

Substantiation of this criteria in the medical record would be necessary to clinically validate the diagnosis of sepsis.

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.

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

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

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

The turn around time is dependent on our contract agreement with Illinois FFS Medicaid.

The findings from this analysis are reported to the client, along with recommendations regarding proper payment of the claim.

Determination Notification

Based on RAC determination a notice is sent to the provider informing them of the results.

If the notice is the result of a Claim Clinical finding of inaccurate billing, we'll provide detailed clinical rationale to support the determination.

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

Preliminary Finding Letter

Preliminary Finding Letter

- Indicates that a claim review resulted in a finding of inaccurate billing and provides dispute instruction to HMS

- The notification letter is comprised of:

01. Cover letter

- Instruction for provider agreement
- Instructions for requesting:
  - Dispute in writing
  - Request must be received within 30 calendar days

02. Audit Detail

- A listing of all claims reviewed and indication of whether each claim was approved or identified as an overpayment.
- Each claim overpayment will provide specific information to explain why it was overpaid.

- If the medical record review resulted in no overpayment determination, the provider would receive a No Further Action Letter

Final Finding Letter

Final Finding Letter

- Indicates that a claim review resulted in a finding of inaccurate billing and provides Administrative Hearing and payment agreement option instructions to the provider to submit it to the IL HFS-OIG within 60 calendar days

- The notification letter is comprised of:

01. Cover letter

- Instructions for provider agreement
- Instructions for requesting Administrative Hearing
- Administrative Hearing must be submitted within 60 calendar days

02. Audit Detail

- A listing of all claims reviewed and indication of whether each claim was approved or identified as an overpayment
- Each claim overpayment will provide specific information to explain why it was overpaid

Disputes and Appeals

Dispute Process

Dispute a RAC finding:
Dispute in writing within 30 days of notification of overpayment to HMS

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

Providers are encouraged to call HMS Provider Relations to discuss and resolve issues

Dispute Response Letters

Dispute Overturn Letter

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

Dispute Uphold Letter

- Review of additional documentation concludes that initial determination was accurate

Appeal Process

Appeal of a RAC final finding: Appeal in writing within 60 days of notification of overpayment to HFS-OIG

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

Providers are encouraged to call HMS Provider Relations to discuss and resolve issues

Provider Relations

Open Communication

- HMS encourages providers to contact us with their concerns and questions

- We view our one-to-one discussions as ideal opportunities to provide education, answer any questions and alleviate concerns

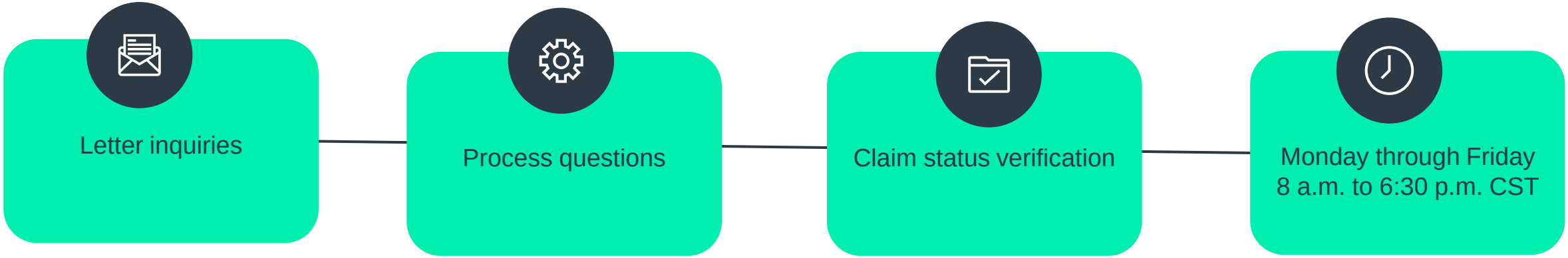
- Our Provider Relations team stands ready to guide you throughout the entire process

Provider Support

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

HMS Provider Relations Line **855-699-6292**

Illinois Contact Information: HFS.OIG.BMI.RAC@illinois.gov



Educational Opportunities

Education and Outreach

Format	Purpose	Method	Contact Initiator	Recipient
IL Provider Notification	Notice of RAC activities (included in Medical Record Request Letter)	Mail	IL Gainwell	Provider
HMS Provider Website	Provide an overview of the RAC audit, review process, FAQs, and notable links to HMS and IL	Web-based	Gainwell	Provider
Provider Webinar	Provide an overview of the audit and review process, answer questions and provide solutions	Web-based	IL Gainwell	Provider
Telephone Calls / Email	Provide an overview of the audit and review process, answer questions and provide solutions	Telephone Email	Gainwell	Provider
Provider Portal	Allows providers to manage medical records with HMS: submission, audit, findings letters, and disputes	Web-based	Gainwell	Provider

Thank you

for attending and we look forward to working together.

Contact
gainwelltechnologies.com

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