A Gainwell Technologies Company

Illinois Medicaid Recovery Audit Contract

Findings Review

Webinar Goals

01

Overview on HMS Review Process

- Scenario Methodology
- Review Process

02

Provide Information

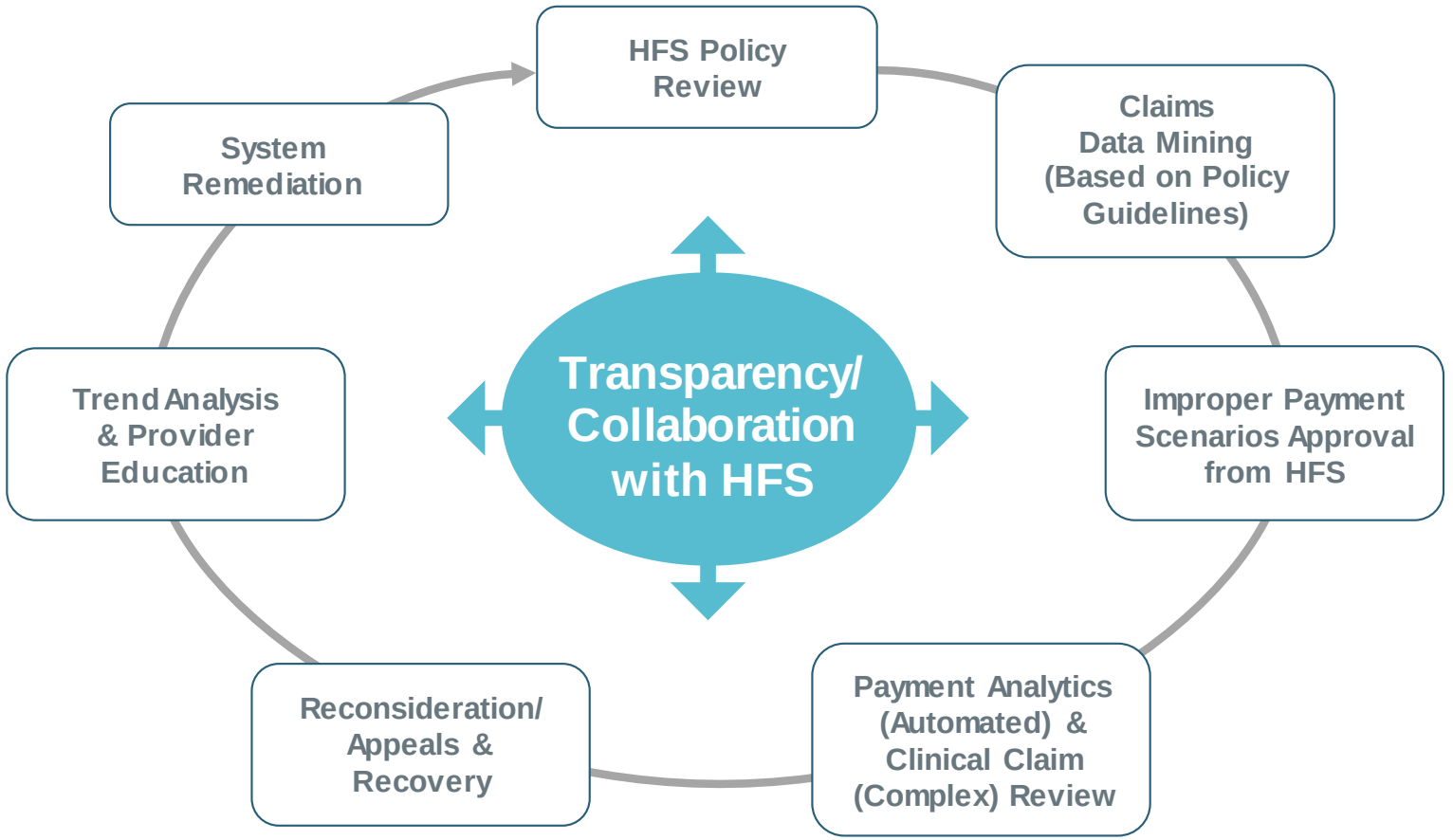
- Scenario Overview
- Regulation and Policy Reference
- Types of Findings
- Next Steps

03

Resources

Overview of Review Process

RAC Scenario Life Cycle



Clinical Claim/ Complex Review

Clinical Claim/ Complex Reviews

Clinical Claim/Complex Review is required when analysis identifies a potential improper payment that cannot be automatically validated.

01 **Records Request**

02 **Preliminary Findings**

03 **Reconsideration (if applicable)**

04 **Final Notice of Recovery**

Clinical Claim Review/Complex Scenarios

DRG Coding Validation

DRG Validation Scenario Description

- HMS employs data mining techniques to identify potential scenarios for improper payments. Data analysis is performed on inpatient hospital claims paid under the Diagnosis Related Group (DRG) system to validate the accuracy of the provider's ICD-9 CM and ICD-10 CM coding of diagnosis, procedures and other coding that impact the DRG assignment. DRG's are assigned using the principal diagnosis, additional diagnoses, the principal procedure and additional procedures, age, sex, and discharge status. The purpose of DRG validation is to ensure the diagnostic and procedural information and the discharge status of the recipient, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the recipient's medical record.

- Beginning July 1, 2014, HFS processes inpatient hospital claims utilizing the All Patient Refined Diagnosis Related Group (APR-DRG) payment system. Inpatient claims prior to this date were processed utilizing the HFS DRG payment system.
  - Review medical record documentation to validate the DRG assignment.
  - Validate the accuracy of the hospital's coding of all diagnoses and procedures that impact the DRG.
  - The review is based on accepted principles of coding practice consistent with established coding guidelines utilizing the version in place at the time the services were rendered.
  - Reviews are conducted by experienced certified coders.
  - Reviewer documents identified errors and recodes and/or regroups the claims to the appropriate DRG.

Inpatient Hospital Review Appropriateness of Setting

Appropriateness of Setting Scenario Description

- The Handbook for Hospital Services, Chapter H – 200 , Policy and Procedures, Section H – 262 states " General inpatient hospital services are defined by the department as those services ordinarily provided by licensed general hospitals, other than those identified inpatient services for which the department has established specific participation requirements. Inpatient services are covered when a patient's medical necessity for services on an inpatient basis are documented. Reimbursement will not be made for services that were billed as acute inpatient care and subsequently denied in the review process as not being medically necessary.

- Clinical review is conducted to determine if an admission to an inpatient status rather than an outpatient or observation setting was appropriate based on Illinois Medicaid accepted clinical criteria. HMS may make a determination that certain conditions and types of inpatient hospital care, services and supplies are not a covered benefit as inpatient hospital care when evaluation and study of such conditions and types of care, services and supplies results in a finding that such care, services and supplies are not required to be performed on an inpatient hospital basis.

- A component of the clinical review process targets claims where an inpatient setting, versus an outpatient or observation setting, may not have been the most appropriate decision, based on Illinois Medicaid's accepted clinical criteria. HMS will refer to McKesson Interqual® Guidelines for accepted clinical criteria regarding admission status and level of care determinations. Clinical reviews result in individual claim determinations based on appropriate medical literature.

- Clinical review judgment involves two steps: (1) the synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient and (2) the application of this clinical picture to the review criteria to make a reviewer determination on whether the clinical requirements in the relevant policy have been met.

Regulation and Policy

State Regulation

Illinois Medicaid Policy and Procedures, Chapter H-200, Handbook for Hospital Services, Section H250.1, Inpatient Reimbursement Methodologies

- http://www2.illinois.gov/hfs/SiteCollectionDocuments/h200.pdf

Federal Regulations

ICD-9-CM for Hospitals Vol. 1, 2 & 3, Coding Guidelines, Section II, A, B, C, D, E, F, G, H, ICD-9-CM Addendums and Coding Clinics. ICD-10-CM for Hospitals

- http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm
- https://www.cdc.gov/nchs/icd/icd10cm.htm

Pursuant to section 1903(a)(1) of the Social Security Act, Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Additionally, pursuant to 42 CFR § 433.312(a), the State must refund the Federal share of unallowable overpayments made to Medicaid providers. Additionally, 42 CFR § 433.304 states that an overpayment is the amount that the Medicaid agency paid to a provider in excess of the amount allowable for furnished services.

- http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=b9c2d880a9f1a9fccc48725ca09340cd&rgn=div5&view=text&node=42:4.0.1.1.4&idno=42#42:4.0.1.1.4.6.23.5

Findings Notices

Preliminary Finding

Agreement with the Preliminary Finding

- No additional steps required at this time

Disagreement with the Preliminary Finding

- Submit reconsideration documentation back to HMS within 30 days of date of Preliminary Finding letter
  - Request must include the Preliminary Finding Letter in order to properly route documentation
  - Request must include disputed claim information
  - Any additional documentation to support your request to overturn the finding

Final Notice of Recovery

Agreement with the Final Notice of Recovery

- Return the enclosed Payment Agreement to HFS-OIG within 60 days of the date of the letter
  - Form must be Signed and Notarized
  - Payment by Cashier's or Certified Check
  - A copy of the Final Notice of Recovery Letter must be included

Disagreement with the Final Notice of Recovery

- Notify HFS-OIG in writing of your intent to appeal within 60 days of the calendar date of the Final Notice of Recovery letter
  - Request must be in writing
  - Request must include disputed and undisputed amounts
  - Request must identify basis for contesting recovery
  - A copy of the Final Notice of Recovery must be included

Sample Language

Example Preliminary Finding

Health Management Systems, Inc. (HMS) has been assigned as the Recovery Audit Contractor (RAC) for the Illinois Department of HealthCare and Family Services-Office of Inspector General (HFS-OIG). Pursuant to Section 6411 of the Patient Protection and Affordable Care Act of 2010, HMS is authorized to audit provider payments for Fee-For- Service claims; to identify under and over payments; and to recover any over payments made to the provider.

HMS has completed a review of selected claims and records you submitted. The objective during the review process was to determine if claims submitted for payment were in conformance with Medicaid policy. The purpose of this letter is to inform you of the preliminary review findings.

Enclosed is an audit detail report(s), which presents the results of the review as preliminary findings detailing the specific overpayment for each claim. The report identifies areas where overpayments may have been made to you. This amount is not subject to recovery at this time, pending a final determination of the overpayment amount at the completion of the audit process.

If you disagree with these preliminary findings, you have the opportunity to provide any documentation that would support Medicaid payment for these services. If you wish to submit additional documentation it must be received within thirty (30) calendar days of the date of this letter.

Additional documentation may be submitted to HMS- Illinois Recovery Audit Services:

HMS - Illinois RAC Services
Fax: (855) 278-3507
Please only fax 30 pages or less

HMS - Illinois RAC Services
5615 Highpoint Drive
Mail Stop #200 - IL
Irving, TX 75038

Example Final Notice of Recovery

HMS previously sent you a preliminary findings letter and an audit detail report. The preliminary findings letter provided you with an opportunity to submit additional documentation to HMS if you had reason to disagree with the finding.

You have not notified HMS that you disagree with the findings, and you have not provided additional documentation or other information to support your position. Based on the documentation available to HMS at the time of audit, HMS has concluded its overpayment determination is accurate. Enclosed is an audit detail report(s), which presents the results of the review as final determination findings detailing the specific overpayment for each claim. This amount is now subject to recovery.

If you agree with this final overpayment determination, you must return the Payment Agreement and repay any overpayment within 60 days of the date of this letter, pursuant to 42 U.S.C.A. Section 1320a-7k(d) and 305 ILCS 5/12-4.25(L). HFS-OIG may recover the overpayment by offsetting the amount against pending or future remittances or by accepting a direct payment in full. Enclosed with this notice is a copy of the Payment Agreement. Please contact HMS Provider Services at: (855) 699-6292, if you have questions pertaining to the Payment Agreement, or if you need any additional information. The Payment Agreement must be mailed, along with a copy of this letter, **within sixty (60) calendar days of the date of this letter** to the following address:

Illinois Department of Healthcare and Family Services Office of Counsel to the Inspector General (HFS-OIG) 2200 Churchill Road, Building A-1 Springfield IL 62702 Attn: RAC Payment Agreements

If you disagree with this final audit determination, you have the right to appeal pursuant to the hearing process established at 89 Illinois Administrative Code, Parts 104 and 140. You must notify HFS-OIG of your intent to appeal by making a written request for a hearing, identifying each disputed and undisputed overpayment amount, and briefly identifying the basis for contesting the recovery. The written notice of intent to appeal must be mailed, along with a copy of this letter, **within sixty (60) calendar days of the date of this letter** to the following address:

Illinois Department of Healthcare and Family Services Office of Counsel to the Inspector General (HFS-OIG) 401 South Clinton Street 6th Floor Chicago, IL 60607 Attn: RAC Appeals Or email: HFS.OIG.RAC.Appeals@Illinois.gov

For correct handling and delivery, please enclose a copy of this letter with all correspondence. HMS cannot be responsible for inappropriate routing when a copy of the letter is not attached.

Example Audit Detail Page

DRG/Newborn DRG Audits

	Original:	Revised:		Original:	Revised:		Original:	Revised:
Principal Diagnosis:	T50901A	T50.901A	Principal Procedure:			Discharge Status:	01	01
Secondary Diagnosis:	R011	G92	Secondary Procedure:			DRG Assigned:	8124	8123
Diagnosis 3:	F329	N17.9						
Diagnosis 4:	F1910	E87.2						
Diagnosis 5:	G92	M62.82						
Diagnosis 6:	K219	N39.0						
Diagnosis 7:	M6282	R01.1						
Diagnosis 8:	J45909	F32.9						

Narrative:

The hospital reported a secondary diagnosis code assignment of J9600 ACUTE RESPIRATORY FAILURE, UNSPECIFIED WHETHER WITH HYPOXIA OR HYPERCAPNIA. Clinician review of the submitted medical records for Clinical Validation of billed codes indicates that the specific diagnosis for code assignment J9600 ACUTE RESPIRATORY FAILURE, UNSPECIFIED WHETHER WITH HYPOXIA OR HYPERCAPNIA is not validated and has been removed as a diagnosis code assignment consistent with documentation received, for the following reasons:

- *Documentation supports that the intubation was done for airway protection and protection to staff and self due*
- *The patient had normal respiratory effort and normal oxygen saturations with no documentation of respiratory distress*
- *Oxygen supplementation via nasal cannula is often provided in the home setting and is not considered, in of itself, a treatment for acute respiratory failure*
- *Extubated next day without difficulty*

The above change results in revised DRG 8123.

Audit Message:

Documentation does not support claim as billed

Example Audit Detail Page

Appropriateness of Setting

Review Summary:
Presentation: This 34 year old female presented to the hospital with vomiting and abdominal pain. Past Medical History: Hypertension, Mixed Anxiety and Depressive Disorder, Helicobacter Pylori-Associated Gastritis, Gallstones. Evaluation/Treatment: As documented in the submitted medical record the following evaluations and or treatments substantiate our findings.

- Physical examination revealed VS: 98.7-81-18-146/98, O2 sat 97% on RA, moist oral mucosa, clear lungs, regular heart rate and rhythm, resolved abdominal pain, no further vomiting, negative abdomen, in no acute distress
- Laboratory studies: White Blood Count Elevated, Potassium Low, Urinalysis Positive, Urine Cultures Positive, Serology for H. Pylori Positive
- Diagnostic studies: CT scan of the abdomen and pelvis showed stable hepatic steatosis, cholelithiasis, minimal omental umbilical hernia, no active disease
- Treatment Received: IV Analgesics, IV Antiemetics, IV Fluids, IV and PO Electrolyte Replacements, PO PPI, PO ACEi, PO Thiazide, Telemetry Monitoring
- Response to treatment: vomiting and abdominal pain resolved, K improved, negative physical examination, wanted to go home
- The patient's symptoms improved and the patient was discharged to outpatient follow-up

The evaluation and management of this patient should have been provided at a lower level of care. This case has been reviewed with a determination made utilizing InterQual Level of Care Criteria as the basis for initial findings. The review of the medical record does not justify medical necessity for inpatient admission to an acute care hospital. An outpatient or observation setting would have been appropriate for the evaluation and or treatment of this patient. Pursuant to the Illinois Handbook for Hospital Services, Chapter H – 200 , Policy and Procedures, Section H – 262 states " General inpatient hospital services are defined by the department as those services ordinarily provided by licensed general hospitals, other than those identified inpatient services for which the department has established specific participation requirements. Inpatient services are covered when a patient's medical necessity for services on an inpatient basis are documented. Reimbursement will not be made for services that were billed as acute inpatient care and subsequently denied in the review process as not being medically necessary.

Example Payment Agreement Form

HFS-OIG PAYMENT AGREEMENT AND AGREEMENT FOR CORRECTIVE ACTION

The Illinois Department of Healthcare and Family Services Office of Inspector General (HFS-OIG) performed an audit of Medical Assistance payments made to **PROVIDER NAME**("Debtor"), with a principal place of business at **PROVIDER ADDRESS CITY AND STATE**. The population for this review consisted of all individuals who participated in the Medicaid program as administered by the Illinois Department of Healthcare and Family Services. This study includes dates of service starting on **AUDIT PERIOD BEGIN DATE** to **AUDIT PERIOD END DATE**.

Debtor has reviewed, understands, and concurs with the audit findings and, in full resolution of the final audit amount, enters into the following Payment Agreement and Agreement for Corrective Action.

Should the Debtor fail to meet any of the conditions in the performance of this agreement, including a default of the repayment terms, Debtor agrees that HFS-OIG shall be entitled to immediately recover from the Debtor the entire balance of the original audit amount and Debtor further agrees to waive any and all rights to any further Administrative Hearing, Judicial Review or any other right to appeal this matter, and thereby agrees to the automatic termination of the Debtor's eligibility to participate in the Medical Assistance Program and to otherwise bar the Debtor's owners, a person with management responsibility for the Debtor, an office, partner, person or entity owning (directly or indirectly) 5% or more of the shares of stock or evidence of ownership of the Debtor from any further participation in the Medical Assistance Program. Whether the Debtor shall be so terminated or barred pursuant to this provision will be a decision made by, and at the sole discretion of, the Inspector General pursuant to 89 Ill. Admin. Code 140.16.

PAYMENT AGREEMENT

For value received, Debtor agrees to pay the Department of Healthcare and Family Services the sum of **$OVERPAYMENT AMOUNT** through the payment agreement option initialed below:

Debtor agrees to pay this amount in (Check and initial requested option of repayment):

OPTION 1: PAYMENT IN FULL

_____ Payment in full of **$OVERPAYMENT AMOUNT.** Debtor shall submit a check payable to Healthcare and Family Services to the following address no later than sixty (60) calendar days of the Final Notice of Recovery Letter.

Healthcare and Family Services
OIG – Collections Unit
2200 Churchill Road, A-1
Springfield, IL 62702
Attn: RAC Payment Agreement

OPTION 2: INSTALLMENT PAYMENT

_____ Twelve (12) monthly check installment(s) which consists of one (1) payment of **$OVERPAYMENT INSTALLMENT 1** and eleven (11) payments of **$ OVERPAYMENT INSTALLMENT 2.** The first installment contains a 5% interest charge of **$INTERESTAMT**. Debtor shall submit a check payable to Healthcare and Family Services to the address above. The first installment shall be due no later than sixty (60) calendar days of the date of the Final Notice of Recovery. All subsequent installments will be due by the 1st of each month following the month of the first installment until the debt is settled in full.

By choosing the Installment Payment option, Debtor further agrees that the Department shall be entitled to recover interest from the Debtor on any such final audit amount, determined to be due and owing from the date of said final audit amount, through the date Debtor returns the sum, at a rate of 5% per annum. Any such interest amount shall be due immediately upon the OIG Collections Unit's receipt of the first installment and, in the event of a default, shall continue to accrue until the sum has been fully satisfied. (305 ILCS 5/12-4.25(E-10), 89 Ill. Admin. Code 140.15 (d) and 89 Ill. Admin. Code 104.206 (d).

Example Payment Agreement Form

Consistent with your selection above indicate by claim line Payment in Full or Installment amount and Total Settlement Amount or Indicate with an X where you intend to file a Formal Appeal

Claim Number	Service From Date	Service To Date	Claim OverPayment Amount	Formal Hearing	Payment in Full	Installment Agreement
12345678910	YYYYMMDD	YYYYMMDD	$XX.XX			
12131415161	YYYYMMDD	YYYYMMDD	$XX.XX			
81920212223	YYYYMMDD	YYYYMMDD	$XX.XX			
				Total Settlement		

BY _____

TITLE _____

DATE _____

PAYEE NUMBER _____

PAYEE NAME _____

ADDRESS _____

Sworn to and subscribed before me this_____Day of_____, 20_____

_____ My commission expires _____

Notary Public

Resources

Resources

01

HMS Provider Services at (855) 699-6292

02

www.hms.com/us/il-providers/home/

03

ilrac@hms.com

04

www.hms.com