



Health First Colorado Recovery Audit Contract

RAC Overview

2017



Agenda

1. Introductions
2. Health First Colorado Recovery Audit
Contract (RAC) Summary
3. HMS Overview
4. Health First Colorado RAC Scope
and Process
5. Resources
6. Question and Answer

Introductions





Health First Colorado RAC Summary



*Background
on the
Recovery
Audit
Contractor*

- **Medicare Modernization Act of 2003 created a demonstration project to identify Medicare overpayments**
 - Operational from 2005 through 2007
 - Made permanent in 2008

- **Section 6411(a) of the Affordable Care Act expanded RAC to Medicaid.**
 - Identification of improper payments
 - Coordination of audit efforts with state audit efforts
 - Education to providers

- **Colorado Revised Statutes (CRS)**
 - CRS Section 25.5-4-301

- **Code of Colorado Regulations (CCR)**
 - 10 CCR 2505-10
 - Section 8.015.8B
 - Section 8.076.2-3
 - Section 8.130.2A




HMS Overview



HMS Vision and Mission

- **Vision:** Making the healthcare system work better for everyone
- **Mission:** We work passionately to increase the value of the healthcare system so that healthcare dollars can benefit more people.



HMS Health First Colorado RAC Approach

Identify improper payments through analysis of paid Health First Colorado claims.

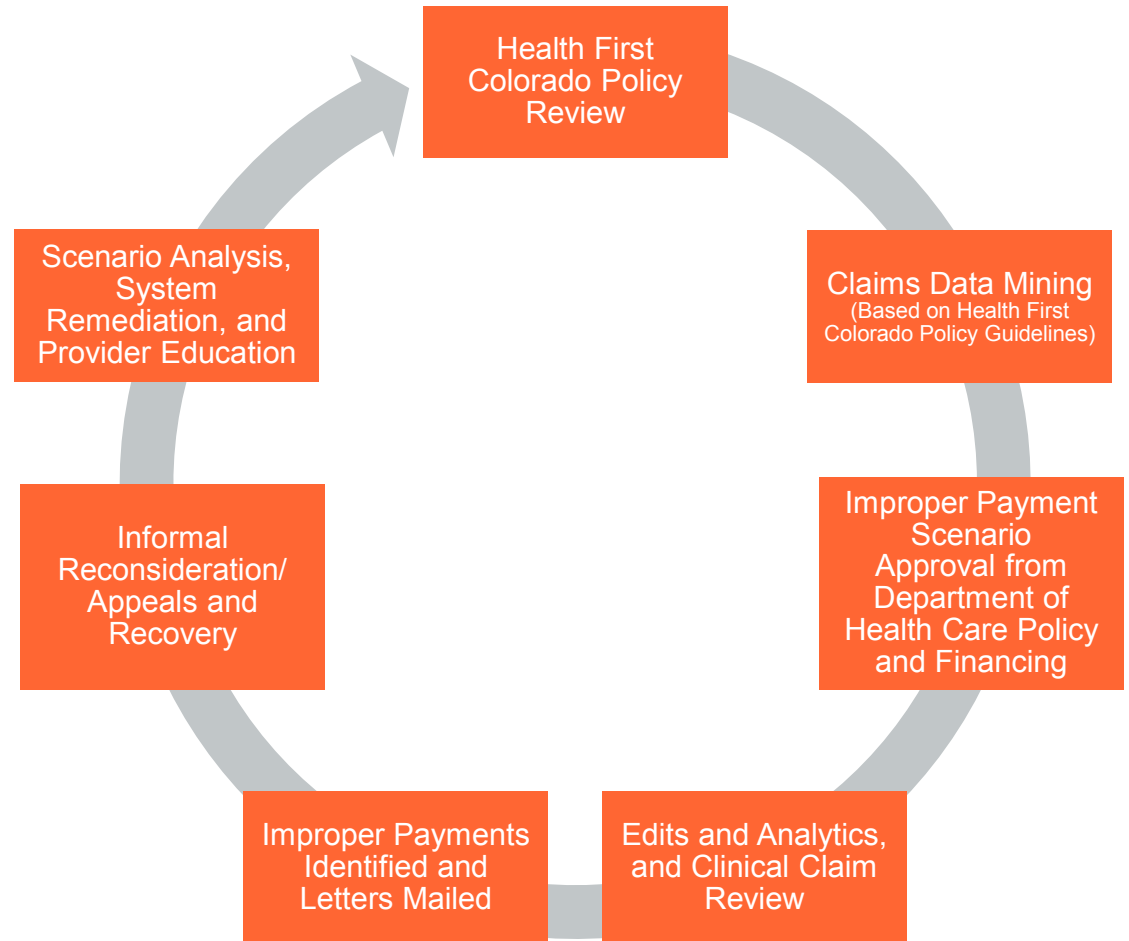
Deliver results grounded in quality, integrity and accuracy to policy.

Partner with the Single State Agency to ensure a fair and consistent process.

Ensure clear, concise, and timely communication with providers.

Afford all providers their rights to appeal.

HMS Health First Colorado RAC Scenario Life Cycle





Health First Colorado RAC Scope and Process




*Health First
Colorado
RAC Scope*

- **Lookback period:** Up to seven years from the claim paid date
- **Claim Types:** All claim and provider types are included



Types of Reviews

- **Automated Reviews** are used when improper payments can be identified clearly and unambiguously using paid claims data
 - Examples:
 - Services rendered after date of death
 - Services rendered to recipients no longer eligible for Health First Colorado
 - Duplicate payments
- **Complex Reviews** are required when data analysis identifies a potential improper payment that cannot be automatically validated so a review of supporting documentation is required
 - Examples:
 - DRG coding
 - Short-stay/Place of service reviews
 - Hospital readmissions

The diagram is set against a green background on the left side of the slide. It features the title 'Automated Review Process' in a white, italicized serif font. To the left of the text are several white line-art icons: a network of nodes and lines, a circular flow diagram, and a circular diagram with internal lines. On the right side, four horizontal arrows of increasing length point to the right, each containing a step of the process in a colored rounded rectangle and a list of details in a lighter shade of the same color. The steps are: 1. RAC Algorithms Applied to Paid Claims Data (teal), 2. Improper Payments Identified (blue), 3. Notice of Adverse Action Issued (dark blue), and 4. IR, Appeal, Recovery (purple).

Automated Review Process

RAC Algorithms Applied to Paid Claims Data

- Improper payment scenario submitted to HCPF
- HCPF approval

Improper Payments Identified

- InterChange review
- Data validation

Notice of Adverse Action Issued

- Certified mail
- Serves as the provider's audit notification and communicates audit results. Providers do not receive notice prior to this notification for Automated reviews.
- Providers are given 30 calendar days from letter date to respond
- Letter copies available on HMS Provider Portal

IR, Appeal, Recovery

- Informal reconsideration (IR):
 - Additional documentation submitted and reviewed, final decision reached
- Formal Appeal
 - Hearing held and final decision reached
- Recovery
 - Overpayment returned to HCPF



Complex Review Process

Medical Records Requested

- Certified mail
- Serves as provider's notice of audit. Providers will not receive any audit plan or schedule in advance of this notice
- Providers are given 45 calendar days from letter date to respond
- Providers may request an extension through HMS within 15 calendar days for additional time to return records
- Providers can send in their Medical records on paper, via electronic media (CD) or via SFTP
 - To submit via SFTP contact HMS

Records Reviewed & Improper Payments Identified

- HMS completes review
- Data validation
- Findings shared with HCPF
- Exit Conference held, as requested by provider

Notice of Adverse Action Issued

- Certified Mail
- Providers are given 30 calendar days from letter date to respond
- Letter copies available on HMS Provider Portal

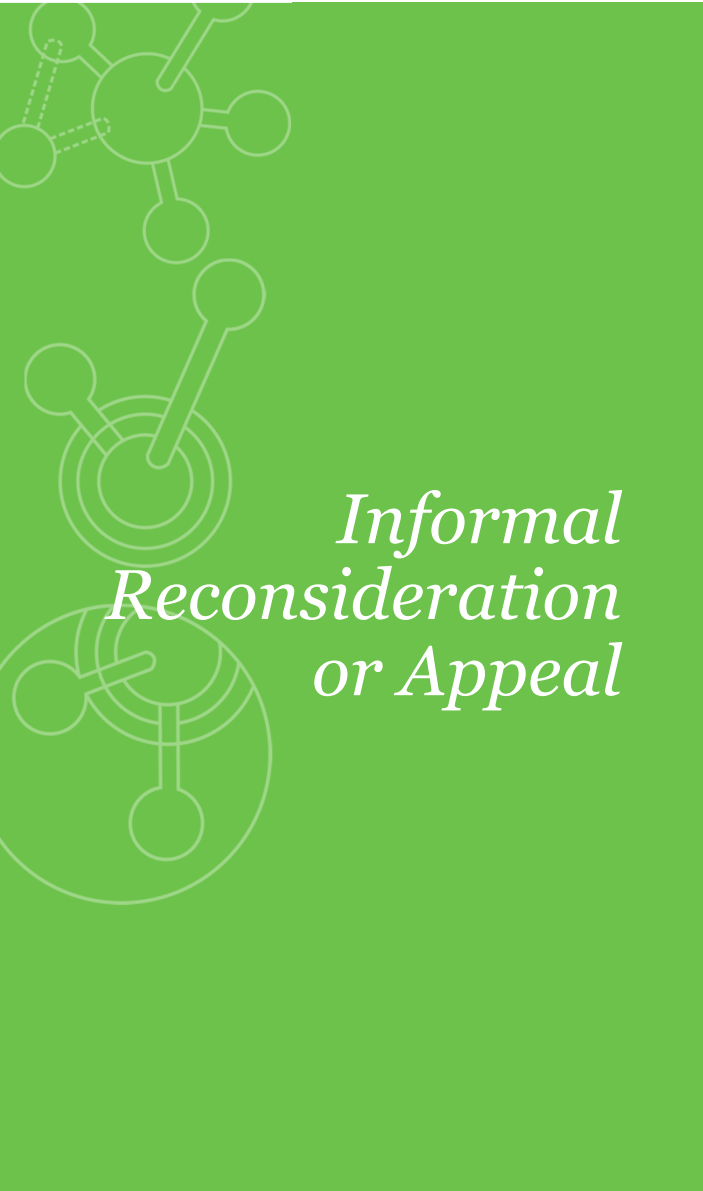
IR, Appeal, Recovery

- Informal reconsideration:
 - Additional documentation submitted and reviewed, final decision reached
- Formal Appeal
 - Hearing held and final decision reached
- Recovery
 - Overpayment returned to HCPF



Exit Conference

- Exit conferences are optional and must be requested by the Provider.
- Requested exit conferences are held once HMS has completed the review and before the Notice of Adverse Action is issued.
- Providers may request the Department be present at the conference.
- HMS will host the conference and provide discussion on:
 - Overpayment findings
 - Documentation used to make the findings
 - Missing documentation that might change the result
 - Next steps in the review process
 - Ways to avoid making same errors in the future



Informal Reconsideration or Appeal

- **Informal Reconsideration (IR)**

- **30 Days:** An Informal Reconsideration request must be submitted in writing within 30 days of date of the Notice of Adverse Action
- New additional documentation, not already provided, must be submitted with the request.
- The specific overpayments being challenged must be identified.
- The reason for the request must be provided.

45 Days: HMS will complete the reconsideration and issue a decision within 45 days.

- **Appeal**

- **30 Days:** An Appeal must be filed with the Office of Administrative Courts within 30 days of the date of the original Notice of Adverse Action or Informal Reconsideration response.
- Instructions for submitting a formal appeal are included on the Notice of Adverse Action.

Claims submitted for IR or formal appeal will not be recovered until after the IR or appeal is finished.

Review Timing

Automated Review



Agree – 30 days from the date of the Notice of Adverse Action to return overpayment to the Department



Disagree– 30 days from date of the Notice of Adverse Action to submit Informal Reconsideration Request



Disagree– 30 days from date of the Notice of Adverse Action or Informal Reconsideration response to file appeal to Office of Administrative Courts

Complex Review



45 days to submit medical records (submission options and instructions listed on Medical Record Request Letter)



10 days to request Exit Conference from date medical records are submitted



60 days for HMS to complete review and notify provider via Notice of Adverse Action



Agree – 30 days from the date of the Demand Letter to return overpayment to the Department



Disagree– 30 days from date of the Notice of Adverse Action to submit Informal Reconsideration Request



Disagree– 30 days from date of the Notice of Adverse Action or Informal Reconsideration response to file appeal to Office of Administrative Courts



Resources



Provider Portal

- Web-enabled, real-time, reliable, secure
- Leading technology designed for Provider accessibility
- Streamlines access to information
 - Update provider demographics
 - Monitor review status
 - Access electronic copies of letters
- Please visit <https://ecenter.hmsy.com>
 - Instructions for New User Registration
 - **Once enrolled, it is important to update your RAC-related contact information to ensure proper routing of all RAC documents and notifications**

A graphic on the left side of the slide, set against a purple background, features a network diagram. It consists of several interconnected nodes (circles) of varying sizes, some solid and some dashed, connected by lines. The nodes are arranged in a hierarchical or branching structure, with some nodes having multiple connections to other nodes. The overall appearance is that of a stylized network or organizational chart.

*CO RAC
Dedicated
Provider
Contacts*

- CO Provider-specific website:
<http://hms.com/us/co-providers/home>
- CO Provider-specific toll-free number
(Monday – Friday, 8:00am – 5:00pm MT):
[\(877\) 640-3419](tel:(877)640-3419)
- CO Provider-specific email address:
CORAC@hms.com

*Project
Contact
Information*



Jeremy Evans, Program Director

Jeremy.Evans@hms.com

208.639.8241



COLORADO
Department of Health Care
Policy & Financing



Kim Nguyen, Provider Payment Review Unit Supervisor

Kim.Nguyen@state.co.us

303.866.6575

Alyssa Gilger, Contingency Based Contract Manager

Alyssa.Gilger@state.co.us

303.866.2253



Enterprising healthcare



hms.com