



Texas Medicaid Recovery Audit Contractor

Frequently Asked Questions

1. What is the look-back period for the Recovery Audit Contract (RAC)?

The look-back period is 5 years, beginning with the service start date, excluding the most recent 365 days.

2. What provider types should be prepared for a RAC review?

The scope of the Medicaid RAC includes all provider types.

3. What types of reviews will be performed by the RAC?

HMS may perform different types of reviews to identify potential overpayments, including:

Automated/Semi-Automated Reviews — Required when improper payments can be identified clearly and unambiguously from claim data elements and established Texas Medicaid policies and rules, without examining medical records or other documents. These reviews are normally performed as a desk audit.

Complex Review — Required when data analysis identifies a potential improper payment that cannot be automatically validated through data elements and established policy and rules alone. The review requires the examination of records or other documents. These reviews are normally performed as a desk audit.

4. How do I submit medical records that were requested?

HMS will accept provider submissions of records on CD/DVD or via fax.

HMS Recovery Audit Services

5615 High Point Dr
Mail Stop #200-TX
Irving, TX 75038

Or

Fax to 855-278-3502 (maximum one record at a time)

5. How long do I have to respond to a review?

Providers have 30 days from the date of the initial record request letter.

6. Will extensions be allowed if delays occur in obtaining documentation needed?

No. Extensions will not be allowed during the RAC Audit process.

7. After I have received the RAC's overpayment determination, may I ask for an additional review?

Yes. Providers have 30 days from the adverse determination letter to request a reconsideration from the RAC.

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8. Will I have an opportunity to respond to the 1st level appeal determination notification?

Yes. A provider will have 120 days from 1st level appeal determination letter to submit a final appeal of an automated or complex review. Final appeal rights notification and instruction will be included in 1st level appeal determination letter.

9. What are the allowed mailing limits:

HMS is able to mail up to 150 records requests each month to providers with over \$2 million in annual Medicaid billing and up to 40 records requests each month for providers with less than \$2 million in annual Medicaid billing.

10. What happens if I fail to respond to a review?

If you do not provide the requested records or notify HMS of your disagreement during the specified timeframe, the affected claims will be adjusted and the overpayment will be recouped.

11. Provider Portal

Providers can sign up for access to the provider portal using the link below. This access allows providers to make updates to their address, view claims that are in review and pull any letters that have been issued.

<https://prodidm.hmsy.com/>

To get new access click on “Start here for new access” for assistance please call provider services.

12. How can I easily identify correspondence that is mailed to providers or entities who are subject to RAC review?

HMS will mail all RAC review correspondence in an envelope with a blue stripe and a priority gram trademark on the front. This distinct colored envelope allows providers to easily distinguish an envelope with RAC review correspondence from any other mail.