HMS Federal Solutions
Region 4
Recovery Audit Contractor

Region 4 Part A RAC Claim Reviews & Recovery Audit Process
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Agenda

- Meet HMS Federal – RAC Region 4
- Review Types Performed
- Medical Record Submission
- Approved New Issues
- Discussion Process
- Provider Portal
- HMS Contact Information
- Open Q&A
The RAC Program’s mission is to reduce Medicare improper payments through the efficient detection and correction of improper payments.

- HDI was the RAC for Region D
- HDI was acquired by HMS in December of 2011
- HMS Federal was awarded the Region 4 RAC Contract on October 31st, 2016
- HMS Federal is a fully owned subsidiary of HMS
HMS Federal’s RAC team includes highly qualified individuals that come together to provide you with the best service possible.

More than nine years of experience with the Medicare Recovery Audit Program.

A complex review team with expertise in Medicare payment rules and regulations for all provider and claims types.

Dedicated Account Management and Provider Services teams have relevant Medicare claims or billing experience to ensure top quality processes and customer service.
Medicare Fee for Service RAC Regions – HMS Federal Region 4 RAC
Review Types Performed
Types of Review

- Post-Payment Claim Reviews on all A/B MAC claim and provider types
  - Inpatient Hospital
  - Outpatient Hospital
  - Physician/Non Physician Practitioner
  - Laboratory/Ambulance
  - Skilled Nursing Facility
  - Inpatient Rehabilitation Facility
  - Critical Access Hospitals
  - Long Term Care Hospitals
  - Ambulatory Surgery Center
  - Other (such as Comprehensive Outpatient Rehabilitation Facilities, Rural Health Clinics, and Independent Diagnostic Testing Facilities, excluding DMEPOS, Home Health and Hospice)

- Three (3) year look back period on all initial RAC reviews
Automated Reviews

- System identified
- Does not require review of medical documentation for claim determination
- Informational Letter is issued to the provider for notification of improper payment
- Claims are held for 30 days from the date of the letter to allow the provider a discussion period review prior to the claim adjustment
- Claims may be sent to the Medicare Administrative Contractor (MAC) for adjustment on day 31 or upon completion of a discussion period which resulted in an uphold of the initial claim determination
Complex Reviews

- Medical records required
- Clinical review of medical records completed within 30 days of receipt
- Medical Necessity determinations are made by Registered Nurses or Therapists
- Coding determinations are made by certified coders.
  - All Reviews are performed under the direction of the Contractor Medical Director (CMD)
- Review Result letter is issued to provider upon completion of review for Findings and No Findings decisions
- Claims are held for 30 days from the date of the letter to allow the provider a discussion period review prior to the claim adjustment
- Claims may be sent to the Medicare Administrative Contractor (MAC) for adjustment on day 31 or upon completion of a discussion period which resulted in an uphold of the initial claim determination
Medical Record Submission
Additional Documentation Requests (ADRs) are sent on a 45-day cycle.

Institutional ADRs are issued in accordance with the CMS established new annual ADR limit baseline.

Providers have 45-days to respond to request for medical documentation.

Providers are allowed at least one (1) extension for the submission of medical records on each claim.
ADR Limits

- New annual ADR limit baseline is one half of one percent (0.5%) of the provider’s total number of paid Medicare claims from a previous 12 month period.

- After three (3) 45-day ADR cycles, CMS will calculate (or recalculate) a provider’s Denial Rate, which will then be used to identify a provider’s corresponding “Adjusted” ADR Limit.

- Upon completion of three (3) ADR cycles and recalculations of the ADR limits by CMS; the RACs may choose to either conduct reviews of a provider based on their Adjusted ADR Limit (with a 6 month look-back period) or their baseline annual ADR limit (with a 3 year look-back period).

What are my options for sending medical records?

- Fax: (702) 240-5517
- Postal Mail
  - Images on CD/DVD or
  - Paper
- (esMD): Information for submitting imaged documentation via esMD may be found at:

Will I be reimbursed for the cost of producing medical records?

- $.12 per page for reproduction of PPS provider records, plus first class postage.
- $.15 per page for reproduction of non-PPS institutions and practitioner records, plus first class postage.
- Providers (such as critical access hospitals) under a Medicare reimbursement system receive no photocopy reimbursement.
- The maximum amount per medical record will not exceed $25.00.
Date:

Reference ID:
Attention:
Address:

NPI:
PTAN:
Phone:
Fax:

Request Type & Purpose: Additional Documentation Required and Request for Medical Records

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce improper payment of Medicare claims. The Recovery Audit Program, mandated by Congress, has been developed to assist in accomplishing this goal.

Reason for Selection
1) Complex review(s) approved by CMS:
Date

Attention:
Address Line 1
Address Line 2

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained HMS Federal Solutions (HMS Federal) to carry out the Recovery Audit Contract (RAC) program in Region 4. The RAC program is mandated by Congress and has a primary goal of identifying Medicare improper payments. Improper payments include overpayments and underpayments. Improper payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of outdated fee schedule or billing for services that do not meet Medicare’s coverage and/or medical necessity criteria, etc.
Approved New Issues
Automated New Issues

- Hospital Discharge Day Management Service
- Not a New Patient
- Office Visits Billed for Hospital Inpatient
- Visits to Patients in Swing Beds
- Inpatient Psych Billed without Source of Admission Equal to “D”
- Home Services Billed for Hospital Inpatients
- Global Surgery – Pre- and Post-operative Visits
- Excessive Units of Hospital Services
- Cataracts Billed with Unit > 1 or Multiple Claims
- Annual Wellness Visits
- Visits to Patients in Swing Beds
- Not a New Patient – Ophthalmology Codes
- Add-On Codes Paid Without Required Primary code
- Global vs. TC/PC Split
- Ambulance During Inpatient Hospital Stay
- Evaluation and Management (E/M) Coding in Skilled Nursing Facility

* Approved New Issues may be subject to change; current as of 08/31/17*
Complex New Issues

- Medical Necessity - Sacral Neurostimulation
- Cataract Removal
- Inpatient Hospital MS-DRG Coding Validation
- Trastuzumab (Herceptin), J9355 - Multi-Dose Vial Wastage
- Complex SNF Review - Documentation and Medical Necessity
- Endomyocardial Biopsies and Right Heart Catheterizations

Additional information regarding approved new issues including Medicare Regulation references can be found on HMS’ website at: New Issues (https://racinfo.hms.com/)

Approved New Issues may be subject to change; current as of 08/31/17
Discussion Period
Process
The Discussion Period begins with:

- Automated Reviews – Informational Letter
- Complex Reviews – Review Results Letter

Discussion Period Process

- Submit completed Discussion Form and supporting documentation to HMS
- Option to elect Peer-to-Peer Review
- Confirmation of receipt of discussion material will be posted to HMS’ Provider Portal within 1 business day
- Discussion documentation is reviewed by a separate independent reviewer
- Written discussion determination is sent to provider within 30 days and outcome is posted to the provider portal
- Discussion Period requests received more than 30 days from the date of the informational or review results letter date will not be reviewed by the RAC
Peer-To-Peer Discussion Request

- Allows the opportunity for the physician to discuss the review findings with the Contractor Medical Director (CMD)
- Can also be requested by a physician employed by the provider; requesting physician cannot be a consultant
- Submit completed Discussion Form and supporting documentation to HMS
- Contact HMS’ Provider Services Department to schedule a peer-to-peer discussion at:
  - Part A Contact Number (877) 350-7992
- Discussion Period requests received more than 30 days from the date of the informational or review results letter date will not be scheduled for a physician peer-to-peer discussion by the RAC.
- Additional information including the Part A discussion form can be found on HMS’ website at: Provider Information (https://racinfo.hms.com/)
Provider Portal
The HMS Provider Portal allows providers to:

- Customize mailing address for ADRs and letters
- Review all approved new issues
- View overall ADR limit
- View & Track Additional Documentation Requests
- Confirm receipt of medical documentation
- Track the status and outcome of medical reviews
- Confirm receipt of discussion material and correspondence
- View discussion period information
- View appeal status
- Track claim closures
How can I customize my mailing address for Region 4 ADRs and correspondence?

- Existing customized contact information has been migrated to the new Region 4 portal
- New providers are initially required to complete the Knowledge Based Authentication (KBA) to obtain user credentials
- 2-Factor Authentication required for all established user login attempts
- Portal accepts up to 7 contacts per organization
- Portal User Guides can be found at: https://racinfo.hms.com/Public1/KnowledgeBasedAuthentication.aspx
Additional Documentation Request Tracking Page

**Additional Documentation Request Tracking**

Please allow 5 business days for the receipt of a Medical Record to process. If it has been more than 5 days, please contact a Provider Relations Representative at (877) 350-7992.

Additional Documentation Requests are available for viewing on the Provider Portal for 180 days from the date of the request, per CMS guidelines.

<table>
<thead>
<tr>
<th>RAC Case ID</th>
<th>Medical Record Number</th>
<th>Claim Number</th>
<th>Date Of Service From</th>
<th>Date Of Service To</th>
<th>Patient Control Number</th>
<th>Documentation Requested</th>
<th>Documentation Received</th>
<th>Medical Review Start Date</th>
<th>Medical Review Completed Date</th>
<th>Review Outcome</th>
<th>Claim Closure Date</th>
</tr>
</thead>
</table>

No Records Requested.

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Discussion and Correspondence Tracking

Please allow 1 business day for the receipt of a Discussion or Correspondence to post. If it has been more than 1 day, please contact a Provider Relations Representative at (877) 350-7902.

Discussion and Correspondence requests are available for reviewing on the Portal for 180 days from the date of receipt, per CMS guidelines.

Discussion Tracking

<table>
<thead>
<tr>
<th>RAC Case ID</th>
<th>Claim Number</th>
<th>Date Of Service From</th>
<th>Date Of Service To</th>
<th>Patient Control Number</th>
<th>Discussion Received Date</th>
<th>Discussion Determination Date</th>
<th>Discussion Determination Date</th>
<th>Discussion 2 Received Date</th>
<th>Discussion 2 Determination Date</th>
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</tbody>
</table>

No Discussion Found.

Correspondence Tracking

<table>
<thead>
<tr>
<th>RAC Case ID</th>
<th>Claim Number</th>
<th>Date Of Service From</th>
<th>Date Of Service To</th>
<th>Patient Control Number</th>
<th>Correspondence Received Date</th>
</tr>
</thead>
<tbody>
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</table>

No Correspondence Found.
Appeals Tracking Page

Appeal Tracking

The appeal status listed below is the most current appeal status on file at HMS and may not reflect the most current status of your appeal with your Medicare Appeal Contractor.

Appeal statuses are available for review on the Portal for 100 days from the Disposition Date.

<table>
<thead>
<tr>
<th>RAC Case ID</th>
<th>Claim Number</th>
<th>Date Of Service From</th>
<th>Date Of Service To</th>
<th>Patient Control Number</th>
<th>Level of Appeal</th>
<th>Disposition</th>
<th>Disposition Date</th>
</tr>
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<tbody>
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</tbody>
</table>

No Appeal Found.

* Reference
Level of Appeal:

- C = Clinical Reopening
- R = Redetermination
- Q = QIC

- 3R = Judicial Review
- B = DAB
- J = ALJ

Disposition:

- A = Affirm
- D = Request Dismissed by MAC
- P = Partially Favorable to Provider
- F = Fully Favorable to Provider

- R = Request for Reopening Accepted by the MAC
- S = Determination Pending
- W = Request Withdrawn by Provider
- Z = Remanded Back to Previous Level of Appeal

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# RAC Region 4 CMS Approved New Issues Page

## New Issues Approved by CMS

All new issues that are identified by HMS must first be approved by CMS.

**Number of Records per Page:** 10

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Number</th>
<th>Provider Type</th>
<th>Review Type</th>
<th>Date Approved</th>
<th>Region 4 States</th>
<th>Region 4 MACs</th>
<th>Dates of Service</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Inpatient Hospital MS-DRG Coding Validation</td>
<td>MS-DRG Coding requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate MS-DRGs for principal and secondary diagnosis and procedures affecting or potentially affecting the MS-DRG assignment. Clinical Validation is not permitted.</td>
<td>0001</td>
<td>Inpatient Hospital</td>
<td>Complex</td>
<td>11/09/2016</td>
<td>All Region 4 States</td>
<td>AB MACs</td>
<td>claims that have a &quot;claim paid date&quot; which is less than 3 years prior to the Demand Letter date (automated review)</td>
<td>1. CMS Program Integrity Manual Ch. 6.5.3 A-C DRG Va QIO Manual Section 4130, J. ICD-9 &amp; 10 CM Coding Has Addendum and Coding Clinic, 5. TCD-9 &amp; 10 CM Office and Reporting</td>
</tr>
<tr>
<td>Complex Comprehensive Cataract Removal</td>
<td>Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.</td>
<td>0002</td>
<td>Outpatient Hospital, ASC</td>
<td>Complex</td>
<td>11/09/2016</td>
<td>All Region 4 States</td>
<td>AB MACs</td>
<td>claims that have a &quot;claim paid date&quot; which is less than 3 years prior to the Demand Letter date (automated review)</td>
<td>1. CMS NCD 10.1, 2. CMS NCD 00.10, 00.12, J. Noridian Date 09/16/2013, Revision 09/1/2014, Retirement Date LCD L34203, 5. Novitas LCD L12930, Effective Date 08/9/11/14, Retirement Date 9/30/2015, 6. Novitas LCD L</td>
</tr>
</tbody>
</table>
HMS Contact Information
HMS’ Provider Relations Area is the first line of Provider Communication

- Toll Free Number: (877) 350-7992
- Fax Number: (702) 240-5595
- E-mail Address: racinfo@hms.com
- Address: HMS Federal (HMS)
  9275 West Russell Road,
  Suite 100 – MS 12M
  Las Vegas, NV 89148
- Hours of Operation: 8:00 AM – 4:30 PM (All Region 4 Time Zones)

CMS
- CMS Website: Recovery Audit Program Page
- CMS E-mail Address: RAC@cms.hhs.gov
HMS’ Website

• HMS’ Website
  • Region 4 Homepage (https://racinfo.hms.com/)
  • Forms and Links
  • Region 4 Updates & Announcements
  • FAQs
  • Contact Information
Helpful Hints

What can I do to prepare for a RAC Audit?

- Create Provider Portal user account & customize contact information
- Review CMS Approved New Issues posted to the website
- Monitor the website for announcements and updates
- Fax discussion requests
As a reminder…

- Additional Documentation Requests (ADRs) are sent on a 45-day cycle.
- Providers have 45 days to submit medical documentation.
- Reviews are completed within 30 days of receipt of medical documentation.
- Discussion Requests must be received no later than 30 days from the date of the letter.
- Claims may be sent to the MAC for adjustment on day 31.
Questions?