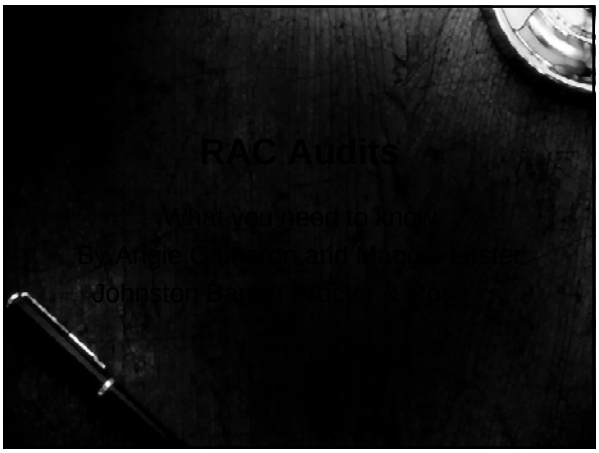

RAC audits

- In early January 2013, Medicaid rolled out its plan for Recovery Audit Contractor Reviews of nursing facilities.
- Purpose - "To ensure the Alabama Medicaid Agency is the payer of last resort as required by the Code of Federal Regulations Chapter 42."
- Or in other words, to identify improperly billed/paid claims.

RAC Audits

- Financial Reviews
  - Review of financial activity for Medicaid eligible residents for a specified review period.
- Clinical Reviews
  - Audit for supporting documentation for necessity of admission and continued stay.

RAC Audits

- Financial Results
  - HMS identified $338,690 in errors for 26 of 35 facilities.
  - Facilities have been notified of the results.
- Clinical Results
  - HMS identified $2,659,296 in potential PASSR errors in 32 facilities.
  - Facilities have not been notified

RAC Audits

- Financial Audits
  - Review includes facility census, aged trial balance report, detailed financial history reports and other relevant financial documentation
  - Improper payments are identified through a comparative analysis of the facility's records, Medicaid claims payment history and eligibility data.

RAC Audits

- Financial
  - Overpayments
    - Increases in social security, pensions and other income collected by the facility but not reflected on the eligibility system and/or claim.
    - Income diversion/deduction overpayments
    - Identification of unapplied resident available monthly income
    - Lump sum income payments made to the facility but not reported to Medicaid.

RAC Audits

- Financial
  - Underpayments
    - Duplicate resident available monthly income in a month
    - Total resident available monthly income applied to claims in a month is greater than the eligibility resident available monthly income amount for the month

RAC Audits - Financial

- Overpayments - Claims
  - Coordination of Benefits (COB) review to ensure Medicaid is payer of last resort
  - Duplicate and overlapping payments
  - Disallowed coinsurance payments
  - Payments made the date of discharge/death and beyond
  - Review of pre-eligibility private payment period
  - Disallowed therapeutic leave bed reservation payments

RAC Audits - Financial

- Audit Review Process
  - Provider Notification
    - Introductory letter from Medicaid
    - Entrance conference with HMS
    - Required documentation provided by provider
    - Desk review by HMS

RAC Audits - Financial

- Documentation
  - Complete census report
    - Must include all payer classes
    - Must be for the entire review period
    - Must detail all admissions, discharges and changes in payer class
  - Current Aged Trial Balance Report
    - Include all payer classes
    - As of the current date or last month closed

RAC Audits - Financial

- Documentation (continued)
  - Financial history report for each Medicaid recipient during review period
    - Must be run through current date
    - For all Medicaid residents who resided in the facility during the review period regardless of whether the resident currently resides in the facility, has been discharged or is deceased.

RAC Audits - Financial

- Process Overview
  - Review performed by HMS
  - Initial findings reported to provider
    - Three reports: Resident Available Monthly Income Overpayment Report, a Claims Overpayment Report and an Underpayments Report
  - Facility will have 30 days to review the report and respond
    - Facility can provide additional information during this time period.

RAC Audits - Financial

- Process Overview
  - Facility may receive a second set of reports called “Needs More Information”
  - Provider will have 14 days to review and respond.

RAC Audits - Financial

- Process Overview
  - Final Improper Payment Review Report
    - Once the second response is received, HMS will send the Final Improper Payment Review Report detailing the amount it plans to recover
    - Both the resident available monthly income and claim improper payments will be included.
    - Facility has 10 days to review and contact HMS to set up an exit conference, “if desired.”

RAC Audits - Financial

- Process Overview
  - After exit conference, HMS submits its Final Improper Payment Review Report to Medicaid

RAC Audits - Financial

- Common errors
  - Dates of service paid were after death or discharge
  - Disallowed hospital bed hold days
  - Home leave days payable by Medicaid exceeded
  - Medicare or MCO covered period
  - Hospice covered period

RAC Audits - Financial

- Common errors (continued)
  - Other insurance covered period
  - Duplicate Medicaid payment
  - Remaining patient funds on facility records for a deceased recipient

RAC Audits - Financial

- As of August 2013, 37 facilities received preliminary letters.
- HMS has completed initial results for 14 facilities.
- All facilities will receive a financial review.

RAC Audits - Clinical

- Purpose - ensure supporting documentation for necessity of admission and continued stay for Medicaid residents.

RAC - Clinical

- Information that supports necessity of admission/continued stay
  - Admission criteria
  - Physician consistently and adequately assesses the resident's need for continued stay and does so within the guidelines
  - Documentation by facility supports need for daily nursing

RAC - Clinical

- Documentation for admission/continued stay
  - MDS assessments completed in required timeframes
  - Care plan is accurate, updated, individualized and reviewed regularly

RAC - Clinical

- Process Overview
  - Introductory letter
  - Record request letter
  - Entrance conference held
  - Medical records sent to HMS
  - Review completed by HMS
  - Preliminary findings/no findings letter

RAC - Clinical

- Process overview (continued)
  - Provider request reconsideration
  - If yes, HMS reviews additional documentation
  - Reconsideration response sent by HMS to provider
  - Provider may request an appeal
  - Following appeal, Final Notice of Recovery sent to provider

RAC - Clinical

- If no reconsideration requested by facility, HMS issues Final Notice of Recovery to provider.

RAC - Clinical

- Goal: To ensure that admissions and stays are "medically necessary"
- Methodology:
  - Review of medical records for the residents in the facility for the review period
  - Review medical record documentation including the MDS, physician orders and progress notes and other relevant documentation.

RAC - Clinical

- Methodology
  - Potential overpayments are identified if the documentation does not support the medical necessity of admission or continued stay

RAC - Clinical

- Recovery
  - Physician did not certify the need for admission or continued stay
  - Medical necessity not established per Medicaid regulations and policy
  - Medical record does not support medical necessity

RAC - Clinical

- The facility will receive notification from Medicaid that HMS is conducting clinical audit.
- HMS will then issue a record request to the facility
- An entrance conference will be held with the facility and HMS

RAC - Clinical Documentation

- MDS
- Form XIX LTC-9
- PASRR
- Physician progress notes
- Physician order
- ST, OT, PT
- Nurses notes
- H&P
- Discharge and Transfer summaries
- Labs
- Radiology
- Interdisciplinary notes
- I/O log
- Vitals
- Weight
- Treatment (TARS)

RAC - Clinical

- Nurse auditor reviews the medical record for compliance and medical necessity
- If significant amount of overpayment is identified for a facility, the review may be expanded to 100% review of Medicaid resident medical records.
- Records will be sent to physician reviewer if overpayment identified for lack of medical necessity.

RAC - Clinical

- Facility will receive either a “Preliminary findings report” or a “No Findings” letter.
- If an overpayment is identified, the facility will have 30 days to review and request reconsideration.

RAC - Clinical

- If facility requests a reconsideration, HMS will review
  - Reconsideration Response Report
    - Preliminary Findings Upheld
    - Preliminary Findings Overturned
  - Provider will have 60 days to request an appeal
  - Appeal handled by Medicaid

RAC - Clinical

- Final Notice of Recovery Report
  - If no reconsideration requested, a Final Notice is issued.
  - If no appeal from reconsideration (if requested), then a Final Notice is issued.

RAC - Clinical

- Common Mistakes
  - Form 161
  - PASRR/OBRA
  - Physician visit

RAC - Clinical

- Form 161
  - Form missing
  - Lack of Medicaid admit date
  - Facility name missing
  - Lack of SSN or Medicaid ID
- To be compliant
  - Completion date same as day of admission or prior to.

RAC - Clinical

- PASRR/OBRA
  - Lack of completion prior to admission
  - Not signing as review after admission
  - Form missing
- Compliant
  - MUST be completed prior to admission
  - Must be signed by RN

RAC - Clinical

- Physician visit
  - Form missing
  - Visits outside of required time frames
  - Must be every 30 days for first 90, then at least every 60
- Physician certification
  - Signed and dated by physician, stating that he is aware of care plan and in agreement that it meets their continued needs of LTC placement.

RAC - Clinical

- Other areas/documentation
  - MDS - at admission and no later than 366 days later, as well as quarterly (every 92 days)
  - Care plans - interventions to validate the need for LTC placement

RAC - Clinical

- Appeals process
  - 60 days from “receipt of ‘Findings’ letter” to dispute any of the findings or request a fair hearing.
  - Facilities may request an informal hearing within 15 days of receipt of Findings Letter.

Appeals

- Fair Hearing
  - A face to face hearing in front of a hearing officer appointed by Medicaid
  - May have legal representation
  - Hearing must take place within 60 days and a ruling must be issued within 90 days of the request.

RAC AUDITS

- Any questions?