



*"People
helping people
help
themselves"*

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RAC Credit Balance Audits of Hospitals Frequently Asked Questions (FAQs)

1. How are hospitals chosen for review?

All hospitals are subject to credit balance audits. Hospitals that are part of a larger network may be grouped based on their network affiliation. All hospitals within a network may be audited together.

2. Are notification letters sent to hospitals before RAC reviews?

Yes. HMS sends a notification letter on HMS letterhead for on-site and desk reviews.

3. To whom are the notification letters addressed?

The State works with the Indiana Hospital Association (IHA) to obtain a list of appropriate contact person for hospitals. If a hospital has not provided a contact name, the notification letter is sent to the billing manager or compliance officer per the IHCP provider record on file.

4. What information is included in the notification letter?

The notification letter describes the requested documentation for the audit. It also provides the auditor's contact information and notifies the provider that HMS will be in contact to establish specific audit details and to set on-site review dates, if applicable.

5. What instructions are given hospitals when they are contacted for review dates?

Hospitals are asked to review their records for payments from Indiana Medicaid that exceeded the "services-rendered-and-appropriately-billed amount." Providers are asked to submit a report of any payments that may have resulted in positive credit balances in their accounts.

6. How many HMS representatives typically participate in on-site reviews?

The number of auditors depends on the size of the hospital and whether the provider will have the needed documents printed before arrival, or if HMS will have to print the documents once on-site. In most cases, a provider can expect one or two auditors. OMPP staff may also participate during the audit.

7. Will HMS request direct access to the hospital's system, or will hospital employees be expected to assist during the on-site review?

The OMPP allows the hospital to provide auditors with access to their system, along with a system expert to assist with navigation, or the hospital can obtain the list of accounts to be reviewed before the on-site review date and provide HMS with the necessary documents.

8. How long does on-site review typically last?

The review team is typically on-site for three days. Depending on volume, additional days may be necessary to complete the review.

9. What records or reports are required for on-site and desk reviews?

Documents requested are UB-04 claims, CMS 1500 claims, all explanation of benefits (EOBs), Remittance Advices (RAs), or denials from all payers, demographic screens, transaction summary screens, copies of any refunds that have been submitted on claims, credit balance reports, debit adjustment reports, and any other documentation that a provider deems necessary to support credit balances.

10. How much time are hospitals given to prepare for the on-site review?

Providers are given 30 days to prepare for the on-site review.

11. Will there be a closing meeting at the end of the review? Who should attend?

All reviews will begin and end with a conference. At the opening conference, the audit process is discussed and hospitals may ask questions or express concerns. At the exit conference, feedback is provided on the audit, and hospitals may ask questions or express concerns. Hospital staff who participates in the audit must attend both conferences. The hospital may also choose to have a more senior staff member attend.

12. Will information need to be sent to HMS to follow up on the review?

In most cases, the hospital will not need to submit any documents to HMS to follow up on the review. On occasion, a hospital may have been unable to complete a document or to review all the findings before HMS' departure. In such instances, the audit worksheets may be left with the hospital, and the exit conference scheduled three to five days later, either over the phone or in person.

13. From the date of the exit conference, how long will it be before an overpayment request with an itemization of accounts is sent by HMS?

The time frame for receiving an overpayment request depends on the hospital's response to the preliminary draft audit findings. The hospital is not obligated to repay the overpayment until after it has received the final calculation of overpayment (FCO) letter, as outlined in the scenarios below:

- a) *Provider agrees with the preliminary draft audit findings:* Within seven calendar days following an audit, HMS will send the provider a draft audit finding of overpayment. If the provider accepts the draft audit findings, the provider waives any rights to contest the findings. HMS will send an FCO letter to the provider within seven calendar days of receiving the provider's written waiver.
- b) *Provider disagrees with the preliminary draft audit findings:* Within seven calendar days of the audit, HMS will send the provider the draft audit findings. If the provider does not agree with the draft audit findings, the provider may request administrative reconsideration. The FCO letter will not be mailed to the provider until the State has

reviewed the documentation submitted with the request, and the reconsideration process between the provider and the State has concluded.

14. If there are overpayments, how is repayment made?

Repayments should be made by check, payable to the State of Indiana and mailed to the Surveillance and Utilization Review (SUR) lockbox at:

**IHCP Program Integrity Department
Attn: SUR Audit Overpayment
P. O. Box 636297
Cincinnati, OH 45263-6297**

Indiana law requires repayment within **300 calendar days** of receiving the FCO letter. However, federal law requires repayment within **60 calendar days** of receiving the FCO letter, or a provider may be subject to the *Federal False Claims Act* and *Whistleblower* provisions of the *Patient Protection and Affordable Care Act* (PPACA). See **IC12-15-13-3.5(e)** and **42 U.S.C. § 1320a-7k(d)**.

15. How will the Medicaid accounts be adjusted in the State's system?

The State will apply the check payment to every claim identified on the worksheets in IndianaAIM.

16. If the hospital does not agree with the overpayment request, what is the appeal process?

The audit appeal process is summarized as follows:

DRAFT AUDIT FINDINGS (DAF)

If a possible billing error is identified as the result of a provider utilization review, the OMPP sends the provider a preliminary DAF letter outlining the claims it believes may have been billed in error. The DAF letter explains that the provider has the option to dispute the DAF by requesting administrative reconsideration within 45 days of receipt of the DAF letter from OMPP.

ADMINISTRATIVE RECONSIDERATION

The provider **must** request administrative reconsideration before filing an appeal (see *IC 12-15-13-3.5*). If a request for administrative reconsideration is not made within 45 days, the provider will forfeit the right to appeal and will be issued a final calculation of overpayment (FCO) letter identifying the overpayment amount to be reimbursed to the State within 300 calendar days. If a timely request for administrative reconsideration is received, the OMPP may reconsider the findings based on any evidence presented by the provider. After the reconsideration process has concluded, the OMPP will send an FCO letter to the provider detailing the final determination and the provider's appeal rights.

FINAL CALCULATION OF OVERPAYMENT (FCO)

After completing the administrative reconsideration process, the OMPP issues an FCO letter. The FCO letter identifies the amount of overpayment, and any applicable interest owed on that overpayment. The letter also explains the provider's right to appeal, and the process that must be followed by the provider to maintain and utilize appeal rights.

APPEAL PROCESS

The provider may appeal the findings to the OMPP within 60 calendar days of the receipt of the FCO letter. A Statement of Issues must be filed with the appeal (see *405 IAC 1-1.5-2*). The provider must submit the appeal and statement of issues to the following address:

MSO7
Secretary Debra F. Minott
c/o Jennifer Jenvey
Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration
402 W. Washington Street. Room. Room W374
Indianapolis, IN 46204

REPAYMENT OF OVERPAYMENT

Indiana law requires that the provider repay the amount found on the FCO letter within 300 calendar days of receiving the FCO letter, regardless of whether he or she is eligible for or chooses to appeal the determination.

APPEAL CONCLUSION

In accordance with *IC 12-15-133.5(f)(2)*, if a provider prevails of appeal, FSSA returns the amount the provider repaid to the State, including any interest the provider may have paid and also pays the interest to the provider from the date of the provider's repayment. Questions about this process should be directed to the OMPP Program Integrity Department at 1-800-457-4515 or 317-234-7598.

17. What is the process providers follow when the RAC identifies underpayments?

If the underpayment occurred within the last 12 months, the hospital may adjust the claims through the normal billing process. If the underpayment occurred more than 12 months ago, the RAC educates the providers to avoid future underpayments.

18. Will the State establish medical record limits?

Yes. The State has established medical record limits for provider type 01 – Hospital. As Medicaid RAC audits are identified and approved for other provider types, limits appropriated to each provider type will be determined by the OMPP, and shared with providers and stakeholders.

19. What are the medical record limits for Provider Type 01 – Hospital?

Medical record request limits for Provider Type 01 – Hospital will follow the guidelines below:

- The maximum limit is set per Legacy Provider Identifier (LPI) number.
- The RAC may request no more than 300 medical record per individual audit and no more than 600 medical records per calendar year per LPI.
- The RAC may not make request more frequently than every 90 days.

- The OMPP may give the RAC permission to exceed the limit. Permission to exceed the limit may occur by the OMPP's initiative or by the RAC's requesting permission. The OMPP or the RAC will notify affected providers in writing.

These limits apply exclusively to Medicaid RAC audits of hospitals.

20. Beyond the RAC audits, will providers be audited by OMPP?

Yes. CMS requires each Medicaid agency to maintain an active program integrity operation, which includes surveillance and utilization review of claims, data mining, and desk and field audits. The RAC program supplements these activities. Providers will not be audited on the same claims by any other state agency or state contractor for credit balance issues. The same claims may be audited by other state agencies or any of the state's contractors for issues other than credit balances.

21. Will HMS continue its TPL activities?

Yes. The contract with HMS for third party liability (TPL) work will continue independent of their RAC auditing.