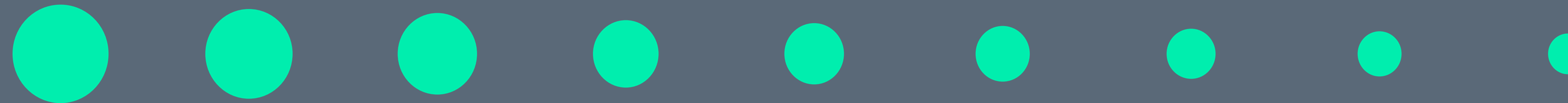
Illinois RAC Dispute Review Process



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RAC Letters

Medical Record Request Letter

- Provider is given **30 days** to submit Medical Records.
- After 30 days, if records have not been received, HMS sends a Follow-up Record Request letter. Provider is given **15 days** to submit records.
- If records are still not received, HMS mails Technical Denial letter that includes Payment Agreement Instructions, due in **60 days**.
- Provider should **not make any payment adjustments** after receiving the RAC Audit notification letter

Preliminary Finding Letter

- Once Medical Records are received, HMS completes the record review within **45 days**.
- HMS mails Preliminary Findings Letter for any claims with Findings.
- Provider is given **30 days** to submit Dispute request

Final Finding Letter

- If HMS has not received a Dispute request within **30 days**, a **Final Finding Letter** is mailed that includes Payment Agreement instructions, due **in 60 days**.

Note: All days are calendar

PRELIMINARY FINDING LETTER

Date: <*MM/DD/CCYY*>

ATTN: <*Title*>
ATTN: <*Dept.*>
<*PROVIDER NAME*>
<*ADDRESS1*>
<*ADDRESS2*>
<*CITY ST ZIP*>

Dear <*Provider Name*>,

Illinois Department of HealthCare and Family Services-Office of inspector General (HFS-OIG) has retained Health Management Systems, Inc., a Gainwell Technologies company, (HMS) to conduct periodic reviews of claims paid by State of Illinois for health care services to ensure the integrity of the paid claims, including coding validation, payment accuracy, compliance with regulations, policies, contractual requirements, and utilization standards. The information in this letter is CONFIDENTIAL and may contain Protected Health Information that may only be re-disclosed in accordance with 45 CFR Parts 160, 162 and 164 (Standards for Privacy of Individually Identifiable Health Information and Administrative Requirements).

HMS has completed a review of the services rendered in connection with the attached claim(s) and has determined that an overpayment in the amount(s) specified was made by Illinois Department of HealthCare and Family Services-Office of inspector General (HFS-OIG). For your reference, the attached Audit Detail page provides a description of the improper payment and the claim(s), or claim lines identified. Illinois Department of HealthCare and Family Services-Office of inspector General (HFS-OIG) will adjust the payment(s) made under these claims in accordance with your provider contract.

If you disagree with our findings, you may request a review of the findings (dispute) by providing additional information or documentation in writing within 30 calendar days of this notification.

A review of findings request should be sent to HMS Dispute Department via:

1. **ELECTRONIC (preferred method)**:
   - HMS Provider Portal https://hmsportal.hms.com/
   - Secure File Transfer Protocol (SFTP)
     For instructions to set up SFTP, please send an email to GoGreen@gainwelltechnologies.com or call 1-855-287-1682

Dispute Request

- If you disagree with HMS findings, you may request a review of the findings (**Dispute**) by providing **additional information or documentation within 30 calendar days of the Preliminary Finding Letter notification**
- The request should contain the details of the audit findings that you are requesting be reviewed, and the **specific additional information included that supports your request**.
- A review will be conducted to evaluate the medical record and **newly submitted information**.
- Results will be mailed to your facility at the conclusion of the review.

Submitting Medical Records

Electronic Method

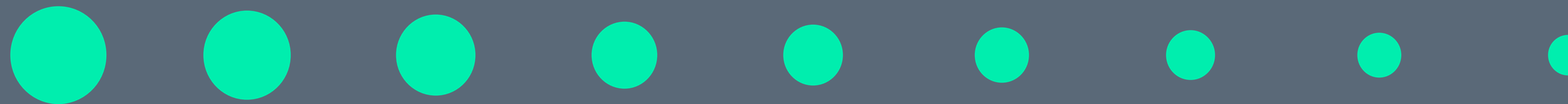
Sending files electronically is the fastest, most convenient and preferred method

- Self register for an HMS Provider Portal account at: https://hmsportal.hms.com
- To set up an SFTP connection, email us at GoGreen@gainwelltechnologies.com
- Data is sent via secure file transfer protocol (SFTP) or through the Provider Portal – both methods are secure

Medical record documentation should include:

- Legible documents with good quality images.
- The **complete** medical record to support the services provided and billed for the dates of service requested.

Place of Service (POS) Dispute Review



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Dispute Review Process

Once the Dispute has been received, HMS completes the record review within **30 days**.

HMS reviews medical records submitted with the Dispute, along with the original documents submitted.

Experienced registered nurses perform the POS Dispute reviews with oversight from the HMS physician team.

HMS reviews the claims and all submitted documentation to validate that the setting, services, and billing are consistent with the documentation.

All Dispute Reviews are completed by a different registered nurse from the nurse who performed the Initial review. The HMS physician review team provides oversight and is available as needed to clinical staff.

Dispute Upheld Letter: HMS concludes the initial determination is accurate (includes Payment Agreement instructions).

Dispute Overturn Letter: HMS concludes the additional documentation identifies no findings of improper billing.

Place of Service Review

Verifies that the place of service billed by the provider was consistent with the patient's condition, care and services provided, as documented in the medical record.

Validates the level of care matches the clinical documentation in the medical record.

Ensure payments are consistent with the services provided.

POS is not a medical necessity determination.

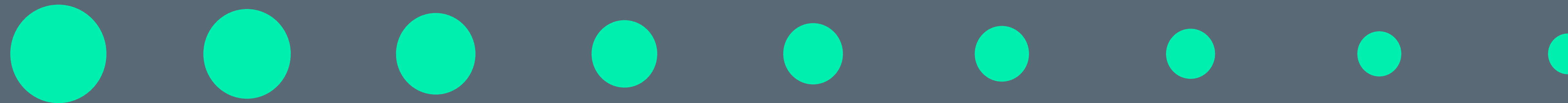
Guidelines and Criteria

- HMS reviews targeted claims to verify that an inpatient level of care was billed appropriately according to State and Federal regulations. Recognizing that CMS standards are often used as payment standards across the industry, HMS works with clients to apply these standards to Medicaid (assuming there is no state mandated regulatory guidance to the contrary).

- Licensed registered nurses with oversight and direction from the HMS physician team use InterQual criteria and clinical review judgement to review the medical record and determine whether the claim was billed consistent with the care delivered. Specifically, the reviewer will determine whether the patient's conditions and the care provided required an inpatient hospital level of care or if the care could have been safely delivered and is routinely provided in a more cost-effective level of care or location.

- The HMS physician team develops proprietary job aids using current literature and standards of care to direct the review activities, provide oversight of the quality and appeals programs and be available to assist reviewers in their case reviews as needed.

InterQual Acute Criteria Review Process



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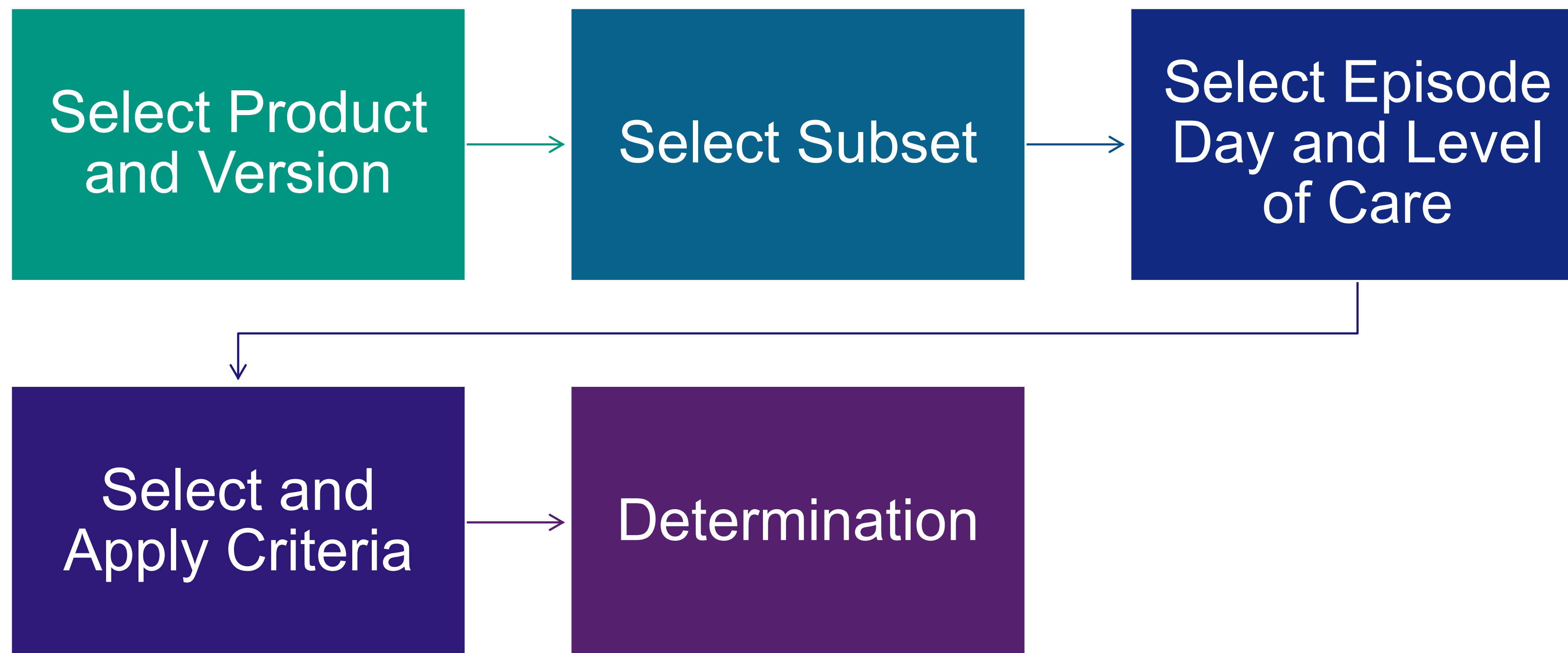
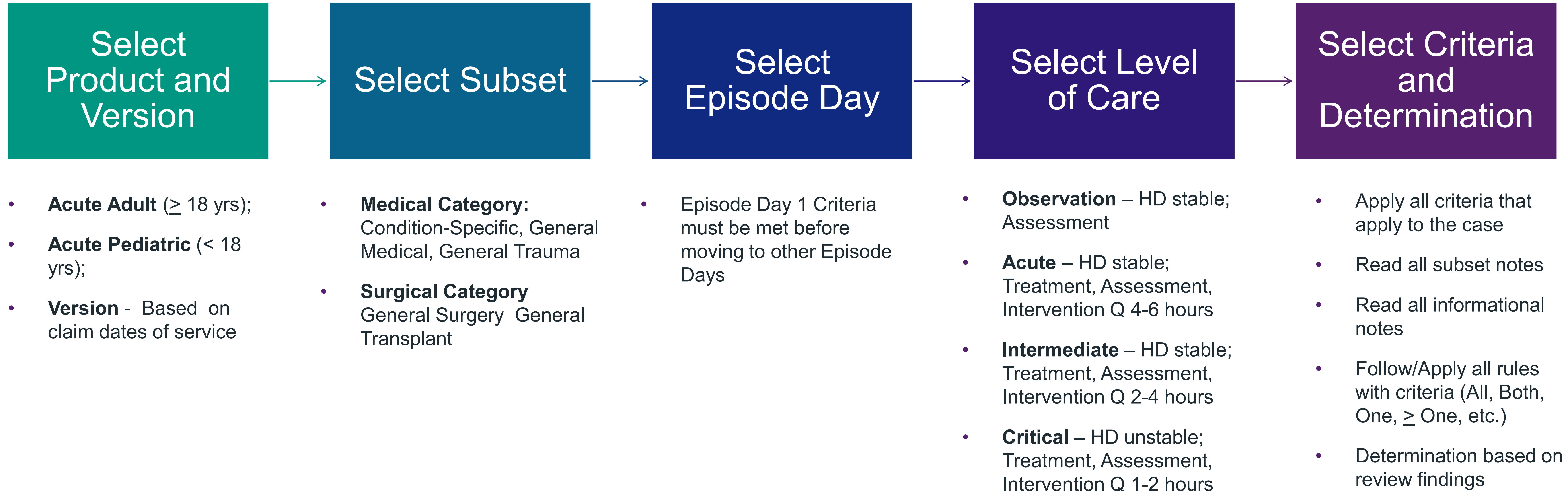
InterQual Acute Criteria Review Process

Supports medical appropriateness of hospital admissions

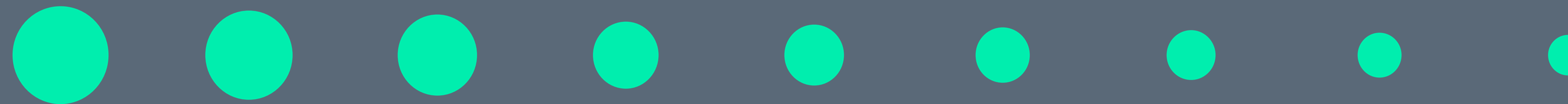


InterQual Acute Level of Care Criteria provides support to determine the medical appropriateness of hospital admissions. InterQual Criteria is used by providers, health plans, payers, and government entities.

InterQual Acute Criteria Review Process
Decision Tree Structure



DRG Clinical and Coding Validation Dispute Review



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DRG Clinical and Coding Validation

HMS Reviews Targeted DRG Claims

HMS verifies all diagnoses and procedure codes were billed appropriately in accordance with Offical Guidelines for Coding and Reporting and are consistent with the documentation in the medical record, resulting in accurate DRG assignment and reimbursement.

DRG Coding Validation

Verify that codes were billed and sequences in accordance with coding guidelines.

Verify the discharge status code and all other elements effecting the DRG assignment

DRG Clinical Validation

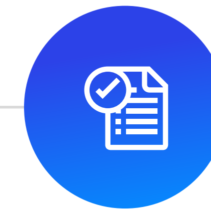
Verifies diagnoses coded were present based on the clinical documentation in the medical record, and the results of related diagnostic testing were consistent with diagnoses.

Guidelines and Criteria

HMS uses nationally recognized criteria and industry standard guidelines for establishing diagnoses.

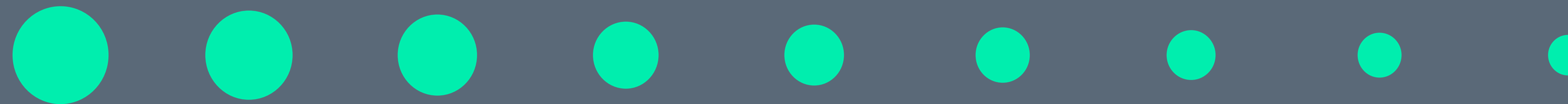
Official Guidelines for Coding and Reporting.

Industry standard criteria and definitions to substantiate the billed diagnoses codes affecting DRG assignment



Criteria that are generally accepted by the medical community from professional guidelines and other evidence-based sources

HMS Provider Resources



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Open Communication

- HMS encourages providers to contact the HMS Provider Relations team with concerns or questions throughout the review process.
- HMS views one-to-one discussions as ideal opportunities to provide education, answer any questions and alleviate concerns.
- HMS Provider Relations team stands ready to guide you throughout the entire process.

Provider Portal Features and Capabilities

Portal Features

- Near real time (24 hour) claim status updates with HMS PI Platform (medical record receipt, review result, reconsideration status, letters)
- **24/7 access** to claim status information
- Dashboard view providing status of all historical and current claims in audit
- Detailed User Guide available in Portal (step by step instruction)
- On demand training videos
- **HMS Provider Relations** support for ongoing education, user registration, and inquiry resolution
- **HMS HelpDesk** support with Portal user access issues (i.e. lockout)

Provider Capabilities

- Locate medical record requests
- Upload of medical records documentation
- Submit a Dispute
- View, print, and obtain copies of HMS Letters
- Verify status of claim
- Update provider address and POC for HMS letters
- My Workload Queue reflecting all claims outstanding requiring provider action
- Claim Export Status Report

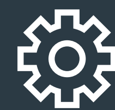
Provider Support

Provider Portal site: https://hmsportal.hms.com/

HMS Provider Relations Line **855-699-6292**

HMS Provider Education Website: https://resources.hms.com/state/illinois/rac

Letter inquiries



Process questions

Claim status verification

Monday through Friday
8 a.m. to 6:30 p.m. CST

HMS, a Gainwell Technologies Company Proprietary and Confidential

Thank you

Jackie Villard, Sr. Regional Director
Gainwell Technologies

Lauren Richardson, Program Director
Gainwell Technologies

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Bureau Medicaid Integrity – BMI

Post Dispute Process

Lisa Castillo, Bureau Chief

Yamneswari Janarthanan, Audit Supervisor

Tiara Mondy, RAC Audit Coordinator Specialist
Office of Inspector General
Illinois Department of Healthcare
and Family Services

RAC – Recovery Audit Contractor

FINAL FINDING LETTER
&
HFS-OIG PAYMENT AGREEMENT OR REQUEST TO DISPUTE AUDIT FINDINGS

CASE management system for processing according to the option selected by the provider.
All options are due within 60 calendar days of the Payment Agreement date to HFS.OIG.BMI.RAC@Illinois.gov

Option 1:
Payment in full
or
Request for offset on future remittance

Offset Request is verified and approved by Collections

Signed copy of PAYMENT AGREEMENT and CHECK.
or
OFFSET request letter uploaded and routed to Collections Department

Option 2:
Installment payment

Signed copy of PAYMENT AGREEMENT for Installment is uploaded and routed to Collections for monitory future payment and case closure.

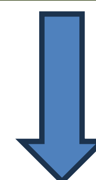
Option 3:
Request to Dispute Audit Findings

Signed copy of PAYMENT AGREEMENT is routed to OCIG for Hearing.

No additional documents are needed.

Offset and Appeal Request

Require information needed for an Offset and an Appeal request



To ensure proper processing, please include the Payment Agreement number and all Claim(s) numbers on the check, along with the fully completed Payment Agreement for processing.

Offsetting the amount against pending or future remittance, subject to approval by COLLECTIONS. Request for payment via offset must be submitted via email to:

HFS.OIG.BMI.RAC@Illinois.gov

Illinois Department of HealthCare
and Family Services
Office of Inspector General (HFS-OIG)
Attn: RAC Collection Unit
2200 Churchill Road, Building A1
Springfield, IL 62702

HFS.OIG.Collections@illinois.gov

HFS-OIG PAYMENT AGREEMENT or REQUEST to DISPUTE AUDIT FINDINGS LETTER

Office of Inspector General
Illinois Department of Healthcare and Family Services

2200 Churchill Road, Building A-1
Springfield, Illinois 62702
https://www.illinois.gov/hfs/oig/Pages/Welcome.aspx

JB Pritzker
Governor

Brian J. Dunn
Inspector General

Date: 09/04/2024

Payment Agreement No:

HFS-OIG PAYMENT AGREEMENT OR REQUEST TO DISPUTE AUDIT FINDINGS

The Illinois Department of Healthcare and Family Services (HFS) Office of Inspector General (OIG) performed an audit of Medical Assistance payments made to with a principal place of business at ("Debtor"). The population for this review consisted of all individuals who participated in the Medicaid program as administered by the Illinois Department of Healthcare and Family Services. This study includes dates of service as of the last three years.

PAYMENT AGREEMENT

The Debtor has reviewed, understands, and concurs with the audit findings and, in full resolution of the final audit amount, enters into the following Payment Agreement (the "Agreement").

In the event of a default by the Debtor in the performance of this Agreement, the Debtor hereby agrees to waive any and all rights to any further administrative hearing, judicial review, third-party arbitration, or any other right to appeal or to dispute this matter, and agrees to the automatic termination of the Debtor's eligibility to participate in the Program and to otherwise bar the Debtor's owners, individuals who have management responsibility for the Debtor, officers, partners, and any person or entity owning (directly or indirectly) 5% or more of the shares of stock or evidence of ownership of the Debtor from any further participation in the Program. Whether the Debtor shall be so terminated or barred pursuant to this provision will be a decision made by, and at the sole discretion of, the OIG. See Ill. Admin. Code tit. 89, § 140.16.

The Debtor understands that it has the duty to ensure a recipient's eligibility before billing for any services. The Debtor agrees and understands that the failure to correct improper billing practices may result in sanctions, including, but not limited to, recoupments, civil-monetary penalties, pre-payment reviews, payment suspensions, summary suspensions, or termination from the Program.

RUP-1118878-11

OPTION 1:
PAYMENT IN FULL

Debtor agrees to pay this amount in (Check and initial requested option of repayment):
OPTION 1: PAYMENT IN FULL

_____Payment in full of $12,373.73. Debtor shall submit a check payable to Healthcare and Family Services to the following address no later than sixty (60) calendar days of the date of Final Notice of Recovery Letter.

Illinois Department of Healthcare and Family Services
Office of Counsel to the Inspector General (HFS-OIG) 2200
Churchill Road, Building A-1
Springfield IL 62702
Attn: RAC Collections Unit

OPTION 2: INSTALLMENT PAYMENT
[12 MONLTHY CHECK INSTALLMENT]

OPTION 2: INSTALLMENT PAYMENT

_____Twelve (12) monthly check installment(s) ($1,059.28) Debtor shall submit a check payable to Healthcare and Family Services to the address above. The first installment shall be due no later than sixty (60) calendar days of the date of the Final Notice of Recovery. All subsequent installments will be due by the 1st of each month following the month of the first installment until the debt is settled in full.

By choosing the Installment Payment option, Debtor further agrees that the Department shall be entitled to recover interest from the Debtor on any such final audit amount, determined to be due and owing from the date of said final audit amount, through the date Debtor returns the sum, at a rate of 5% per annum, as set out in the amortization table below.

Annual Interest Rate	5.0
Years	ONE
Payments/Year	12
Initial Amount	$12,373.73

Payment #	Payment	Prin. Pmt.	Int. Pmt.	Balance
1	($1,059.28)	($1,007.73)	($51.56)	$11,366.00
2	($1,059.28)	($1,011.93)	($47.36)	$10,354.08
3	($1,059.28)	($1,016.14)	($43.14)	$9,337.94
4	($1,059.28)	($1,020.38)	($38.91)	$8,317.56
5	($1,059.28)	($1,024.63)	($34.66)	$7,292.93
6	($1,059.28)	($1,028.90)	($30.39)	$6,264.04
7	($1,059.28)	($1,033.18)	($26.10)	$5,230.85
8	($1,059.28)	($1,037.49)	($21.80)	$4,193.36
9	($1,059.28)	($1,041.81)	($17.47)	$3,151.55
10	($1,059.28)	($1,046.15)	($13.13)	$2,105.40
11	($1,059.28)	($1,050.51)	($8.77)	$1,054.89
12	($1,059.28)	($1,054.89)	($4.40)	$0.00

HFS-OIG PAYMENT AGREEMENT or REQUEST to DISPUTE AUDIT FINDINGS LETTER, cont.

OPTION 3:

REQUEST TO DISPUTE AUDIT FINDINGS

DISPUTE AUDIT FINDINGS

Having reviewed and understood the audit findings, the Debtor declines the above option(s) to remit payment at this time, as shown by the option initialed below:

OPTION 3: REQUEST TO DISPUTE AUDIT FINDINGS

__X__ Should the Debtor choose to dispute some or all the audit findings, a request for referral to the Office of Counsel to the Inspector General for a formal hearing must be submitted within sixty (60) calendar days from **07/25/2024**. The Debtor must identify the total amount of all undisputed and disputed audit overpayments and submit the request to dispute audit findings to the Bureau of Medicaid Integrity via the following email to **HFS.OIG.BMI.RAC@illinois.gov**.

Consistent with your selection above, indicate by claim line Payment in Full or Installment amount and Total Amount of Payment. Indicate with an X where you intend to file a Formal Appeal.

Claim Number	Service From Date	Service To Date	Claim OverPayment Amount	Formal Hearing	Payment in Full	Installment Agreement
[redacted]	12/30/2022	01/04/2023	$2,402.89			
[redacted]	01/09/2023	01/16/2023	$1,435.90	X		
[redacted]	02/02/2023	02/08/2023	$12,287.27			X
[redacted]	04/07/2023	04/07/2023	$4,547.08			
				Total Settlement		

BY ____________________

TITLE ____________________

DATE ____________________

PAYEE NUMBER ____________________

PAYEE NAME ____________________

ADDRESS ____________________

Overview of Appeals of RAC Audit Determinations

Nathan Kipp
Chief Legal Counsel
Office of Inspector General
Illinois Department of Healthcare and Family Services

Overview of Topics

- Introduction to the Office of Counsel to the Inspector General
- RAC Appeals Intake Process
- Pre-Appeal Attorney Outreach
- Summary of Administrative Appeals Processes and Procedures
- Looking to the Future

Introduction to OCIG

- **The Office of Counsel to the Inspector General (OCIG) is the OIG's In-House Legal Department**
- **Responsible for Representing HFS During Administrative Litigation**
  - Matters in which HFS seeks **to sanction enrolled providers**
  - Matters in which HFS seeks **to recover from providers overpayments** identified by audits
  - **RAC audits** are included in recovery actions
- **Relatively Robust Legal Department**
  - Eleven attorneys, four of which are dedicated to RAC matters
  - Four members of administrative staff, one of which is dedicated to RAC matters

RAC Appeals Intake Process

- **OIG Updated its Intake Process as Part of the New Contract to Streamline and Expedite Appeals**
- **Past Process**
  - **No standardized procedure for routing appeal requests** to OCIG
  - **Claims were not consistently consolidated by Hospital**, often resulting in multiple individual administrative appeals, each pertaining to one claim, e.g., 20 separate appeals for 20 claims
  - **Inconsistent outreach** by OCIG attorneys before initiating administrative appeals
- **Current Process**
  - **Appeal requests are regularly referred to OCIG** on a rolling basis via established routes
  - **OCIG aggregates individual claims for each Hospital** until a "**critical mass**" is reached
  - Intent is to consolidate individual claims so that **fewer administrative appeals are necessary**

RAC Appeals Intake Process, cont.

- **"Critical Mass" Size Shaped by Several Factors**
  - Hospital **size**
  - **Total dollar amount** of claims
  - Typically aim for **10 to 20 claims per Hospital** for which appeals are appropriate to proceed
- **Inclusion of Claims Determined By Order of Prioritization**
  - Claims based on **DRG methodology** are prioritized over place-of-service claims
  - Claims with **largest dollar amounts** are addressed first
  - **Age of appeal** is a large consideration – ideally, first in, first out
- **Current Body of Appeal Requests**
  - Total number of **claims appealed**: 1,290
  - Total number of **Hospitals seeking to appeal claims**: 167
  - **Average** number of claims appealed per Hospital: Approximately 8
  - **Ranges** from 1 claim per Hospital to 80

Pre-Appeal Attorney Outreach

- **OCIG Attorneys Will Contact Hospitals Once a "Critical Mass" Is Reached to Confirm that Appeals Should Proceed**
- **Hospitals Can Help to Expedite Outreach By:**
  - Providing OIG with **clear and current lists of individuals** who are authorized to speak with OCIG attorneys and accurate **up-to-date contact information**
  - **Returning OCIG attorneys' communications promptly**
  - **Keeping communication lines open**
- **Hospitals Are Not Required to Act Until Attorney Outreach Occurs**
  - **Hospitals should wait to provide any information** supporting appeals until the administrative process begins
  - Please **do not submit supporting information with requests for appeals**

Administrative Appeals

- **Under Illinois Law, All Appeals Must Be Heard by the HFS Administrative Tribunal, the Bureau of Administrative Hearings (unless settled)**
- **Appeals Process Mirrors Full Adversarial Civil Litigation**
  - Akin to OIG filing suit against the subject Hospital
  - Statutory law, case law, rules of procedure, and rules of evidence all apply
  - Parties regularly appear before administrative law judges (ALJs) for hearings and conferences
  - Expert witnesses have played large roles in past appeals
- **But: Rules of Procedure Slightly Differ from Those in Civil Litigation**
  - Rules are found in the Illinois Administrative Code, beginning at **89 Ill. Admin. Code § 104.200**
  - **Highly recommended to review** once any administrative action is initiated
- **All Hospitals Must Be Represented by an Attorney**
- **No Fees or Court Costs Other than Attorney Fees and Medical Records**

Administrative Appeals, cont.

Matter Referred to OCIG*

Notice of Recovery Filed and Served; Hospital Has 10 Days to Request Hearing

Preliminary Hearing (Approximately 30 Days After Date of Notice)**

Discovery, Motions Practice, Status Hearings, Conferences***

Full Evidentiary Hearing (Trial)

Post-Hearing Motions (If Necessary)

Tribunal's Recommended Decision

Parties' Written Exceptions to Recommended Decision (Briefing)

HFS Director's Final Administrative Decision (FAD)

*OCIG and Hospitals can **settle** claims at any point in this process.

If a Hospital fails to timely request a hearing or does not appear at the scheduled preliminary hearing, the tribunal will enter a **default judgment to recommend recovery.

***Hospitals **should wait** to produce information until discovery begins.

Administrative Appeals, cont.

- **OCIG Has Limited Control Over Length of Appeals Process**
  - Unlike traditional litigation, rules of procedure **do not allow dispositive motions** to seek prompt resolution, e.g., motions to dismiss or motions for summary judgment
  - Each appeal **must proceed to a full evidentiary hearing**, i.e., trial
  - Although parties have input, **ALJs control all scheduling**
  - Recommended decisions are not immediately issued, i.e., **no oral rulings, all written opinions**
  - Counsel for the HFS Director **closely scrutinize recommended decisions** before issuing FADs
  - **Hospitals may further appeal adverse decisions** to circuit court, further prolonging litigation
- **Example of Length of Appeal Under Previous Contract**
  - Notice of Recovery filed **December 2018** (one place-of-service claim at issue)
  - Full evidentiary hearing held **October 2020** (two-day hearing for the one claim)
  - Recommended decision issued **November 2022**
  - FAD issued **March 2023**

Looking To the Future

- **OIG Is Exploring Regulatory Changes to Expedite Appeals Even More**
  - In the meantime, OCIG attorneys are diligently working to move appeals as expeditiously as possible
  - Thank you in advance for your patience
- **Resources for Inquiries**
  - **HFS RAC FAQs**: https://resources.hms.com/state/illinois/rac
  - **OIG-RAC email:** HFS.OIG.BMI.RAC@illinois.gov (please send the completed *HFS-OIG Payment Agreement or Request to Dispute Audit Findings* letter and include the claims number(s) in the email subject line)
  - **Collections email:** HFS.OIG.Collections@illinois.gov (please send the completed *HFS-OIG Payment Agreement or Request to Dispute Audit Findings* letter and include the Payment Agreement number in the email subject line)
  - **OCIG-administered email inbox**: HFS.OIG.RAC.Appeals@Illinois.gov (please provide as much detail as possible to aid responses)

Questions?

Thank You!

Lisa Castillo, Bureau Chief
Nathan Kipp, Chief Legal Counsel
Yamneswari Janarthanan, Audit Supervisor
Tiara Mondy, RAC Audit Coordinator Specialist
Office of Inspector General
Illinois Department of Healthcare
and Family Services