MI Medicaid RAC

Scope of Work

HMS

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Table of Contents

1. Background .................................................................................................................. 2
2. Purpose ......................................................................................................................... 3
3. Period of Performance ................................................................................................. 4
4. Project Launch Meeting ............................................................................................... 5
5. Stakeholder Communication and Coordination ......................................................... 6
6. Project Plan ................................................................................................................... 8
7. Project Approval Process ............................................................................................. 9
8. Identify Underpayments and Overpayments .............................................................. 10
9. Audit Notification - Provider Medical Record Requests .......................................... 12
10. Provider Notification – Review Results ...................................................................... 13
11. Record Review Periods and Appeals ......................................................................... 15
12. Contractor Documentation Requirements .................................................................. 18
13. Calculation of Overpayments ..................................................................................... 19
14. Recovery of Overpayments ....................................................................................... 20
15. Provider Education ..................................................................................................... 22
16. Computer Support ...................................................................................................... 23
17. Data Security ................................................................................................................ 24
18. Disaster Recovery ........................................................................................................ 25
19. Records and Documentation ....................................................................................... 26
20. Quality Assurance ....................................................................................................... 27
21. Staffing ......................................................................................................................... 28
22. Reports ......................................................................................................................... 31
23. Definitions .................................................................................................................. 33
1. Background

Description:
The ACA is comprised of two bills, the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act (HCERA), P.L. 111-152, enacted on March 30, 2010. Section 641 I of the ACA expands the Recovery Audit Contractor (RAC) program and requires States to employ RACs.

This document addresses the subset of State Contract #071B2200127 that encapsulates the State of Michigan Medicaid Recovery Audit Contractor (RAC) requirements.

Medicaid Recovery Audit Contractor for the Michigan Department of Community Health, Contract #071B2200127 is the State of Michigan comprehensive recovery and cost containment contract, which covers all programs for which services are paid under Title XIX of the Social Security Act. State Contract 071B2200127 is exclusively a contingency fee contract, which includes the identification of improper payments for non-covered services, incorrectly coded services including DRG miscoding, duplicate services and claims that violate Medicaid policy.

Payment Integrity initiatives are a key focus of this contract. The contract scope includes:

- All State funded Health Care Programs
- All Beneficiaries
- All Providers
- All Claims (Fee-for-Service, Encounter & Capitation)
- All Over-payments, including but not limited to:
  - Incorrect payments
  - Non-covered services,
  - Incorrectly coded services,
  - Duplicate services,
  - Services not rendered
- Contingency Fee Contract
- Automated Audits (Data matching, Data Mining, and Desk Audits)
- Complex Audits (On-site Clinical)

The full scope and text of State Contract #071B2200127 may be found at: http://www.michigan.gov/documents/buymichiganfirst/2200127_379004_7.pdf
2. Purpose

**Description:**
The RAC Program's mission is to reduce Medicaid improper payments through the efficient detection and collection of overpayments, the identification of underpayments and assistance with implementation of actions that will prevent future improper payments. The purpose of this contract will be to support the State in completing this mission.
3. Period of Performance

**Description:**
Medicaid Recovery Audit Contractor for the Michigan Department of Community Health, Contract # 071B2200127 is effective as of March 12, 2012 and remains effective through March 11, 2015.
4. Project Launch Meeting

**Description:**
The contractor shall meet with the Michigan Department of Community Health - Inspector General (MDHHS-OIG) Contract Manager and other contract stakeholder representatives to outline a schedule for completion of the requirements of this contract. This meeting shall be held at a time and location determined by the MDHHS-OIG Contract Manager.

**HMS Implementation Plan:**
Project Launch Meeting

Date: March 27, 2012

Location: 400 S. Pine Street, Lansing MI
5. Stakeholder Communication and Coordination

Description:
The contractor shall participate in periodic project status meetings, as scheduled by the MDHHS-OIG Contract Manager with associated contract stakeholders including but not limited to representatives from the Department of Human Services, Department of Health and Human Services, Medicaid Fraud Control Unit, Department of Justice, Law Enforcement officials, providers, provider associations, and other entities deemed necessary and appropriate by the MDHHS-OIG Contract Manager to review and coordinate contract activity. These meetings shall be held at a time, location and format determined by the MDHHS-OIG Contract Manager.

The contractor shall coordinate meeting scheduling, prepare and distribute agenda, document and distribute meeting minutes, and maintain and communicate status reports to project stakeholders.

The contractor shall report on suspected quality issues during the periodic project status meetings.

The contractor shall report on suspected fraud issues and/or claims during the periodic project status meetings. The contractor shall refer suspected fraud cases to MDHHS-OIG Contract Manager in the approved format.

HMS Implementation Plan:
HMS shall meet with the MDHHS-OIG Contract Manager and applicable project stakeholders at least monthly to review progress of the work, evaluate any problems, discuss plans for immediate next steps of the project and discuss findings and process improvements that will facilitate MDHHS in paying claims accurately in the future.

The status report shall document all work accomplished during the previous month. These reports shall include the following:
► Complications completing any task
► Update of project plan
► Update of what vulnerability issues are being reviewed in the next month
► Recommended corrective actions for vulnerabilities (i.e. system edit, provider education, etc.)
► Update on how vulnerability issues were identified and what potential vulnerabilities cannot be reviewed because of potentially ineffective policies
► Action items
► Appeal statistics
► Process improvements to be completed by HMS

Ongoing Coordination with Other State Agency Activities
In order to minimize provider abrasion and maximize benefit to the state, HMS shall coordinate all provider reviews with MDHHS-OIG Contract Manager and any other appropriate state agency to ensure no overlap occurs. Additionally, HMS-identified target claims that are already included in ongoing MDHHS-OIG payment integrity efforts will be removed from HMS’s reviews.

Identification of New Findings
HMS shall complete a RAC Improper Payment Scenario Development Request document for each new RAC recovery initiative. The request shall document the overpayment scenario, explaining the methodology used to identify the finding and citing state and federal regulations to establish good
cause for the review of the claim. HMS shall obtain MDHHS-OIG authorization to proceed prior to commencing any RAC recovery.

**Supplement to Ongoing MDHHS-OIG Activities**

With MDHHS-OIG Contract Manager’s Authorization, HMS will assist in ongoing recovery identification and payment recapture efforts.

**HMS Deliverables:**

- Status Meeting Agenda
- Status Meeting Minutes
- Suspected Quality Issue Referral
- Suspected Fraud Referral
- Corrective Action Plan
- RAC Recovery Authorization to Proceed
6. Project Plan

Description:
The contractor shall prepare and submit a Project Plan within two weeks of the Project Launch Meeting. The formal project plan must outline the resources and time frame for completing the work listed. It will be the responsibility of the contractor to update this plan. The project plan will serve as the snapshot of everything the Contractor is identifying at the time. As new issues arise the project plan will be updated.

The project plan must include the following:
1. Detailed quarterly projection by vulnerability issues including:
   a. Incorrect procedure code and correct procedure code;
   b. Type of review (automated, complex, extrapolation)
   c. Type of vulnerability (medical necessity, incorrect coding)
2. Organizational Chart – The organizational chart must identify all key personnel as well as the organizational structure.

HMS Implementation Plan:
Within 15 business days of the project launch meeting, HMS shall prepare our project plan containing in narrative and graphical formats HMS approach, sequence of tasks, project management methodology, and anticipated time for each task’s completion.

HMS shall incorporate MDHHS-OIG Contract Manager feedback and recommendations into the final work plan.

HMS shall obtain approval of work plan from MDHHS-OIG CONTRACT MANAGER, as well as all reports, deliverables, and new project initiatives.

Contract Milestone:

Project Plan

Contract Milestone Start / Due Date:

Launch Date +15

HMS Deliverables:

- Project Plan
- Vulnerability Report
- Organizational Chart
7. Project Approval Process

**Description:**
The contractor shall present ideas for State approval prior to project launch. The contractor is responsible for scenario design and submission of sufficient information to substantiate the project request.

**HMS Implementation Plan:**
HMS will prepare an *Improper Payment Scenario Development Request* document for State review. The form will provide the specific details of each audit project, including background of the issue, supporting regulations, project scope, listing of project stakeholders, provider limitations, possible exclusions and any special requirements that may apply for the scenario.

The request form will be presented to MDHHS-OIG Contract Manager and the scenario will be discussed at the regularly scheduled stakeholder meeting. Prior to approval, MDHHS-OIG or other appropriate state agency will submit the project scenario to the applicable subject matter experts for their input.

After input has been received from the subject matter experts and provided to the stakeholders and to HMS, the MDHHS-OIG will indicate one of the following: whether additional work needs to be done by HMS so that the project can be approved, whether the project is approved; or whether project approval is denied. If approved, the project will receive sign off from the MDHHS-OIG.

The *Improper Payment Scenario Development Request* document, supplemented by a summary of the targeted population, will be submitted for State approval. The document signed by MDHHS-OIG will act as an authorization to proceed with the project.
8. Identify Underpayments and Overpayments

**Description:**
The contractor shall identify and verify the existence of underpayments, and overpayments. These incorrect payments may include but not be limited to the following:
- Incorrect payment amounts
- Non-covered services
- Incorrectly coded services, including DRG miscoding
- Duplicate services
- Claims that violate policy

The contractor shall exclude:
- Incorrect payments that result from Indirect Medical Education (IME) and Graduate Medical Education (GME) payments
- Claims with a date of service more than 3 years past the date that the claim was identified for review for overpayment/underpayment
- Random selection of claims
- Pre-payment reviews

The contractor shall review all potential incorrect payments with the MDHHS-OIG Contract Manager prior to initiating recovery activities.

The contractor must develop detailed written review guidelines as part of its process of reviewing claims for coverage and coding purposes. Guidelines must specify what information should be reviewed by reviewers and the appropriate resulting determination. Contractor must receive approval of the internal guidelines from the MDHHS-OIG and make their internal guidelines available to MDHHS-OIG upon request.

**HMS Implementation Plan:**
HMS shall implement a Recovery Audit Contract process to identify incorrectly paid claims, including both underpayments, and overpayments. HMS’s RAC engagement shall incorporate all State-funded programs, providers, and claims.

HMS shall apply incorrect payment data analysis algorithms to the comprehensive Michigan data repository to identify incorrectly paid claims. HMS shall triage potential actionable claim result populations into two types of retrospective review: Automated Review and Complex Review.

**Automated Reviews**
Automated Reviews are applied in scenarios where improper payments can be identified clearly and unambiguously. In these cases, the improper payment can be determined from claim data elements, and well established policy and rules. HMS obtains approval on the criteria for determining that no more complex review of documentation is required to validate that an improper payment exists.

**Complex Review**
A Complex Review is indicated when the analysis identifies a potential improper payment that cannot be automatically validated. The system flags the case for further review and HMS will then determine what other information may be required to validate that an improper payment exists. Additional records or documentation may be requested from the provider or other appropriate party and then the review
of the additional information to validate the improper payment determination will be performed. On-site auditing and reviewing may also be required.

In development of audit protocols, HMS’s Policy Research team works with experts familiar with each type of improper payment issue as well as with MDHHS as appropriate to develop service type-specific Audit programs, error/policy reference matrices, and Internal Review Guidelines (IRGs), which are audit protocols that ensure that auditors use consistent guidelines in claim review, documentation, MR abstraction, and the application of testing criteria to the services audited. In developing our IRGs, HMS relies on state and federal source authorities and clinical and coding criteria and guidelines applicable to MDHHS. HMS configures IRGs based upon results from our Regulatory and Research Compliance department to ensure that our guidelines are sound and incorporate policies and rules.

**Underpayment**

HMS shall report underpayments identified through both complex and automated reviews on periodic status and findings reports. Underpayments shall be reported separately from overpayments. Identified underpayments will only be reported when, through analysis, it is found that a claim was incorrectly billed at a lower level of payment than appropriate. HMS will not report underpayments in situations where the provider failed to include a provided service on a claim, nor will it process or report underpayments self-disclosed by providers. Providers will be responsible for making the appropriate claim adjustments in CHAMPS in order to obtain the corrected payment amount.
9. Audit Notification - Provider Medical Record Requests

**Description:**
The contractor shall request, obtain, store and share imaged medical records. The contractor shall maintain a document management system, store medical records not associated with an overpayment for one year, store medical records associated with an overpayment for the duration of the contract plus seven years, and maintain a log of all requests for medical records indicating at a minimum, the requester, a description of the medical record being requested, the date the request was received, and the date the request was fulfilled.

The contractor is required to make information about the status of a medical record (outstanding, received, review underway, review complete, case closed) available to providers upon request. Contractor must develop a web-based application for this purpose and provide the MDHHS-OIG Contractor Manager access to this application.

The contractor may obtain medical records by going onsite to the provider’s location to view/copy the records. The RAC shall accept provider submissions of electronic medical records on CD/DVD, secure transmission or fax.

No provider shall be required to provide more than 150 medical records in any one request from the RAC, nor shall any provider be required to provide more than 500 medical records in any 3 month period. A provider may request for an exception to these requirements by submitting their request to the MDHHS-OIG Contract Manager.

**HMS Implementation Plan:**
HMS shall use discretion to ensure the number of medical records in a request do not negatively impact the provider’s ability to provide care. MDHHS-OIG may amend the number of records requested on a particular project, to increase or limit the number of records.

HMS shall not pay for copying medical records.

HMS will make every effort to coordinate with provider. In a situation where an HMS representative is denied access, the case will be referred to the MDHHS-OIG.

HMS will also maintain an Issues/Resolutions document that will address this and other similar topics.
10. Provider Notification – Review Results

Description:
The contractor shall generate notifications of underpayment and overpayment in a format to be reviewed and approved by the MDHHS-OIG. Providers shall be afforded a set period of time to review, and appeal contractor identified claims. The contractor shall have staff and systems available to support the provider notification, and claim review and disposition processes.

Notification shall include minimally required data elements to identify the claim in question and the contractor’s rationale for the overpayment.

The contractor shall periodically, and upon the request of the State or the provider update the providers’ address and point of contact information with the contractor system of records.

The contractor shall maintain a toll free customer service telephone number, and include this number in all correspondence sent to providers or other prospective debtors. The service number must be staffed by qualified personnel during normal business hours (Monday through Friday, from 8:00 a.m. to 5:00 p.m. Eastern Standard Time). After normal business hours, a message must indicate the normal business hours for customer service. All messages to be played after normal business hours or while on hold must be approved by the MDHHS-OIG Contractor Manager before use.

The staff answering the customer service lines shall be knowledgeable about the RAC program. The staff shall have access to all identified improper payments and shall be knowledgeable of all possible recovery methods and the appeal rights of the provider. If necessary, a translator must be provided within 2 business days to speak to a provider.

The RAC shall utilize a Quality Assurance (QA) program to ensure that all customer service representatives are knowledgeable, respectful, and provide timely follow-up calls.

The RAC shall compile and maintain provider approved addresses and points of contact.

The RAC shall respond to written correspondence within 30 days of receipt. The RAC shall provide the MDHHS-OIG Contract Manager with all written correspondence constituting a complaint about the conduct of the RAC, in the overpayment identification or in the recovery methods utilized, within 10 calendar days of receipt. If the RAC is not sure how the correspondence will be interpreted, it should forward the correspondence to the MDHHS-OIG Contract Manager. The RAC shall maintain a written report of contact for all telephone inquiries and supply it to the MDHHS-OIG Contract Manager within 2 business days of request. Contractor phone system must notify all callers that the call may be monitored for quality assurance purposes.

The contractor shall maintain systems to facilitate the timely retrieval of claim details associated with all identified improper payments and have staff knowledgeable of all possible recovery methods and the appeal rights of the provider.

The contract shall maintain a service delivery requirement to return provider’s calls within one business day.
**HMS Implementation Plan:**
HMS shall generate provider notifications in conformity with contract requirements, and with the prior review and approval of the MDHHS-OIG. HMS has in-place provider relations department staffed with knowledgeable associates. HMS has in-place provider toll free number and dedicated to provider relations. HMS has in-place translation capabilities, and hearing impaired compatible technology and protocols.

HMS shall return providers’ calls within 1 business days, and respond to providers’ correspondence within 30 days of receipt.

HMS allows providers to customize their address and point of contact by updating RAC specific information directly in the HMS Provider Portal or by contacting HMS’s Provider Relations.

**Improper Payment Notification**
If the identification and audit/review process determines that an improper payment has been made for a claim, the contractor will develop and submit a *Preliminary Findings of Fact* letter approved by the MDHHS-OIG Contract Manager for each claim.

*Preliminary Findings of Fact* letter will be sent to a designated contact person at each provider. The Audit Report package will contain the following:

- Identification of the provider(s) or supplier(s) name address and provider number;
- Reason for conducting the review;
- Narrative description of the overpayment situation: state the specific issues involved which created the improper payment and any pertinent issues as well as any recommended corrective actions the provider should consider taking;
- Findings for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded; and a reference to the Medicaid Policy and/or State/Federal regulation.
- A list of all individual claims including the actual amounts determined to be non-covered, the specific reason for non-coverage, the amounts denied;
- An explanation of Medicaid’s right to recover overpayments as well as the procedures for recovery of overpayments and the provider’s right to request an extended repayment schedule;
- The provider appeal rights information

The system shall generate one letter even if multiple issues are identified for a single claim. The improper payment rationale and underlying requirement criteria are pulled for each case and printed on the letter. If there are multiple rationales for denying claims submitted for review, there shall be a separate section of the letter for each rationale.

If approved, letters will also notify providers that they may also respond through our secure online Provider Portal, which allows providers to ask questions regarding the audit. HMS maintains all discussions held with providers and all provider comments received through the Provider Portal. In addition, HMS may include a Provider Education Section in the letter intended to help providers improve their billing results in the future.
11. Record Review Periods and Appeals

**Description:**
The contractor shall manage provider review periods having a duration set by the MDHHS-OIG.

**HMS Implementation Plan:**

**Complex audit:**
- **Medical Record Request** letter sent to provider.
- Provider has 30 days to respond to request.
- If no records are submitted a **Technical Denial** letter is issued and the provider has 30 days to provide documentation, adjust claim or submit an Appeal to MDHHS or entire claim will be voided by MDHHS. If HMS’s finding was not a full recoupment of an individual claim, but an adjustment, it is the provider’s responsibility to resubmit a corrected claim to MMIS/CHAMPS. Instructions for resubmitting corrected claims will be provided in the Final Notice of Recovery Letter. These instructions must be followed to prevent timely filing rejections of resubmitted claim(s).
- When records are submitted, HMS has 60 days to review submitted documentation and issue a **Preliminary Findings of Fact** Letter.
- Provider has 30 days to agree and adjust claims in CHAMPS or submit additional documentation to HMS for reconsideration. (See Reconsideration below)
- If provider agrees but does not adjust claim within 30 days, or does not respond at all, a **Final Notice of Recovery letter** is sent to provider.
- Provider has 30 days to agree and adjust claims in CHAMPS or submit an Appeal to MDHHS. (See Appeal below)
- If provider does not respond to the Final Notice of Recovery or does not adjust claims in CHAMPS within 30 days, the entire claim will be voided by MDHHS. If HMS’s finding was not a full recoupment of an individual claim, but an adjustment, it is the provider’s responsibility to resubmit a corrected claim to MMIS/CHAMPS. Instructions for resubmitting corrected claims will be provided in the Final Notice of Recovery Letter. These instructions must be followed to prevent timely filing rejections of resubmitted claim(s).
- Providers must request an internal conference or an appeal for administrative hearing in writing which shall be received within 30 calendar days of the notice of adverse action (i.e. Final Notice of Recovery Letter). If a provider does not submit a request for an appeal within 30 days of the Final Notice of Recovery Letter, the notice of adverse action is final and the department may act on it.

**Automated audit:**
- **Preliminary Findings** letter is sent to provider.
- Provider has 30 days to agree and adjust the claim in CHAMPS or submit additional documentation for reconsideration. (See Reconsideration below)
- If provider agrees, but does not adjust the claims in CHAMPS or does not respond at all, a **Final Notice of Recovery** letter is sent to provider.
- Provider has 30 days to agree and adjust claims in CHAMPS or submit an Appeal to MDHHS. (See Appeal below)
- If provider does not respond to the Final Notice of Recovery or does not adjust their claims in CHAMPS within 30 days, the entire claim will be voided by MDHHS. If HMS’s finding was not a full recoupment of an individual claim, but an adjustment, it is the provider’s responsibility to resubmit a corrected claim to MMIS/CHAMPS. Instructions for resubmitting corrected claims
will be provided in the Final Notice of Recovery Letter. These instructions must be followed to prevent timely filing rejections of resubmitted claim(s).

- Providers must request an internal conference or an appeal for administrative hearing in writing which shall be received within 30 calendar days of the notice of adverse action (i.e. Final Notice of Recovery Letter). If a provider does not submit a request for an appeal within 30 days of the Final Notice of Recovery Letter, the notice of adverse action is final and the department may act on it.

**Reconsideration process:**
When a provider disagrees with the findings from HMS they can submit additional documentation for reconsideration within 30 days of the findings letter.

- HMS has 60 days to review documentation submitted and issue a **Reconsideration Response** letter (Overturned, Amended, or Upheld).
- If the decision is overturned, HMS ceases recovery; no further action is required by provider.
- If the decision is upheld or amended, the provider has 30 days to agree and adjust the claim in CHAMPS or submit an Appeal to MDHHS. (See Appeals below)
- If provider does not respond or does not adjust their claims in CHAMPS within 30 days, the entire claim will be voided by MDHHS. If HMS’s finding was not a full recoupment of an individual claim, but an adjustment, it is the provider’s responsibility to resubmit a corrected claim to MMIS/CHAMPS. Instructions for resubmitting corrected claims will be provided in the Final Notice of Recovery Letter. These instructions must be followed to prevent timely filing rejections of resubmitted claim(s).
- Providers must request an internal conference or an appeal for administrative hearing in writing which shall be received within 30 calendar days of the notice of adverse action (i.e. Final Notice of Recovery Letter). If a provider does not submit a request for an appeal within 30 days of the Final Notice of Recovery Letter, the notice of adverse action is final and the department may act on it.

**Appeals process:**
Provider has the right to appeal any decisions by following the standard MDHHS Appeal process within 30 days of the final notice or reconsideration response from HMS.

- If the conference/hearing results in the decision being overturned, HMS issues a **Final Notice of Appeal Overturned** letter and ceases recovery; no further action is required by the provider.
- If the conference/hearing results in the decision being upheld or amended HMS issues a **Final Notice of Appeal** decision letter (Upheld, Amended) and the provider has 30 days to adjust the claim(s) in CHAMPS, if claim is not adjusted within 30 days the entire claim will be voided by MDHHS.
- Should the provider, and/or MDHHS disagree with the internal conference decision, the provider and/or MDHHS has the right to an administrative hearing. Requests for an administrative hearing must be in writing and made within 30 days of the decision of the internal conference decision.
Providers can request an appeal through standard MDHHS process. Providers should submit an appeal request to:

MDHHS Appeals  
Michigan Department of Community Health  
P.O. Box 30807  
Lansing, MI 48909

Additional information regarding the MDHHS Appeals process can be found in the General Information for Providers section of the Medicaid Manual and in Sections R400.3402 – R400.3424 of the Michigan Administrative Code. Appeal Department contact information can be found in the Medicaid Manual Directory Appendix.

HMS will cease recoupment efforts on appealed claims until a decision is made. If the decision is upheld or amended and payment recovery is necessary, the provider will be responsible for updating the claims in CHAMPS. If HMS’s finding was not a full recoupment of an individual claim, but an adjustment, it is the provider’s responsibility to resubmit a corrected claim to MMIS/CHAMPS. Instructions for resubmitting corrected claims will be provided in the Final Notice of Recovery Letter. These instructions must be followed to prevent timely filing rejections of resubmitted claim(s). If the claims are not adjusted in CHAMPS within 30 days, MDHHS will void the claim in its entirety.

If the provider notifies HMS of the intent to appeal, HMS will notify MDHHS within one business day and provide the written notice if submitted, or contact information if requested verbally.

HMS will assist MDHHS-OIG with support of the overpayment determination throughout all levels of appeal. HMS will provide supporting documentation (including medical record) and appropriate reference to Medicaid policy, federal and State regulations as well as provide assistance by representing MDHHS-OIG at any hearings associated with the overpayment.

**Re-openings of Claims Denied Due to Failure to Submit Necessary Medical Documentation:**

In cases where HMS denies a claim without reviewing the medical record because the requested records were not received or were not received timely and the denial is appealed, the appeals department may send the claims to HMS for re-opening. If this occurs, HMS will conduct a re-opening of claims sent by the appeals department within 30 days of receipt of the forwarded claims and the requested documentation. In addition, HMS will issue a new letter containing the revised denial reason and the information required.
12. Contractor Documentation Requirements

**Description:**
Contractor must include in the case file:
- A copy of all request letters
- Contacts with Medicaid Contractors, MDHHS-OIG, others involved in the case
- Dates of any calls made
- Notes indicating what transpired during the calls

Upon determination of improper payment, contractor must update the case file with:
- The improper payment amount for each claim in question
- Line level claim detail
- The date of the original demand/notification letter
- Appeal status
- Collection detail and/or adjustments due to errors/appeals
- Any other pertinent claim level information

Once an overpayment is identified, contractor must proceed with recovery of Medicaid overpayments.

In order for a contractor voucher to be paid, all supporting information for the voucher must be in the coordination system and on the contractor invoice.

MDHHS will utilize the following reports from the coordination system:
- Report of all collections for the month
- Report of all adjustments and appeals for the month
- Report of all underpayments for the month

**HMS Implementation Plan:**
HMS has developed a Program Integrity Enterprise (PIE) solution that provides the following functionalities:
- Provider Portal
  - Accessible via the Internet to any authorized user with a broadband connection
  - Allows for contact information update, retrieval of medical record request letters, tracking of case updates, and communication with provider relations
- Data (Claim) tracking: maintains claim-level information on each claim that HMS attempts to recover
- Case management
- ImageNow compatibility—links to HMS’s document imaging system
- Documentation of complex review results and tracking reviewer narrative at the claim level
- Case search capability on a variety of attributes
13. Calculation of Overpayments

**Description:**
The contractor shall support the MDHHS-OIG in the calculation and determination of overpayment amount due back to the State. This shall include full and partial claim denials. This contract also may permit overpayment extrapolation calculations if determined to be necessary by the MDHHS-OIG.

A full denial occurs when the RAC determines that:
- The submitted service was not reasonable and necessary and no other service (for that type of provider) would have been reasonable and necessary, or
- No service was provided.
The overpayment amount is the total paid amount for the service in question.

A partial denial occurs when the RAC determines that:
- The submitted service was not reasonable and/or necessary, but a lower level of service would have been reasonable and necessary, or
- The submitted service was up-coded (and a lower level of service was actually performed), an incorrect code was submitted that caused a higher payment to be made, or
- Failure to apply a payment rule causing an improper payment (e.g. failure to reduce payment on multiple surgery cases)

Other situations that are not categorized above should be brought to the MDHHS-OIG Contract Manager’s attention before Contractor sends notification to the provider. In these cases, the contractor must determine the level of service that was reasonable and necessary or represents the correct code for the service described in the medical record. After approval by the MDHHS-OIG Contract Manager, the contractor must proceed with recovery.

For the purposes of contingency fee calculation, the contract shall only earn a fee on the actual program payment recovered. The contractor shall not earn a fee on any associated interest or penalties.

If interest is charged it will accrue from the date of the final determination and will either be charged on the overpayment balance for each full 30 day period that payment is delayed. All payments would first be applied to interest and then to principal.

The RAC will only be paid a contingency payment on the difference between the original claim paid amount and the revised claim amount.

**HMS Implementation Plan:**
HMS shall support the State's directives on calculating provider overpayments, and will work with the MDHHS-OIG to implement claim retractions including full and partial claim denial, and overpayment extrapolation calculations in a manner compliant with MMIS methods, and procedures.

HMS’s contingency fees shall only apply to principal and exclude interest and penalties.
14. Recovery of Overpayments

**Description:**
Contractor must assist MDHHS-OIG in the recoupment of post-appeal Medicaid overpayments that are identified. The recovery techniques utilized by contractor must be legally supportable. The recovery techniques will follow the guidelines of all applicable Medicaid regulations and manuals as well as all federal debt collection standards.

**Adjustment Process**

*Written Notification of Overpayment:*
After identification and validation, if necessary, the contractor must send written notification of the overpayment to the provider within 60 calendar days. The written notification must include appeal rights as well as all necessary information for the provider to be able to fully understand the overpayment. The MDHHS-OIG contract manager will approve all written notification to the provider before letters are sent.

*Recoupment through Claims Adjustments or Current/Future Medicaid Payments:*
Medicaid utilizes the claims adjustment process to recover Medicaid provider overpayments. Every effort to recoup overpayments in this fashion must be exhausted before an alternate recoupment process is considered.

If claim adjustment is not possible for some reason, a gross adjustment process may be used to recover Medicaid overpayment, if approved by the MDHHS-OIG. This is achieved by reducing present or future Medicaid provider payments and applying the amount withheld to the indebtedness. Once payments are withheld, the withhold remains in place until the debt is satisfied in full or alternative payment arrangements are made. As payments are withheld they are applied against the oldest outstanding overpayment. The debt receiving the payments may or may not have been determined by the RAC.

Contractor will receive a contingency payment for all amounts recovered from withholding of present and/or future payments that are applied to the overpayment amount identified by the contractor.

*Repayment through Installment Agreement:*
Contractor may grant a request by the provider to repay the overpayment through an installment plan, following approval by the MDHHS-OIG contract manager. This recoupment option will only be approved in rare occasions.

If an installment plan is approved, contractor must receive a contingency payment based on the amount of each installment payment. As provider submits monthly payments, contractor will receive the applicable contingency payment for the principal amount received.

*Referral to the Department of Treasury:*
Debts that are not fully paid by the debtor or cannot be gross adjusted must be referred to the State Department of Treasury to recoup the overpayment amount. The RAC is required to cease all recovery efforts once the debt is referred to the State Department of Treasury. The Providers will be issued a written intent to refer before the debt is 130 days delinquent.
Compromise and/or Settlement of Overpayment:
The RAC may not compromise and/or settle an identified or possible overpayment. If a provider presents the RAC with a compromise request, the RAC must forward the request to the MDHHS-OIG. The RAC must include its recommendation on the request and the justification for its recommendation. If the MDHHS-OIG determines that a compromise and/or settlement is in the best interest of Medicaid, the RAC will receive a contingency payment for the portion of the principal that is recouped, providing that the RAC initiated recoupment by sending a demand letter prior to the compromise and/or settlement offer being received.

Voluntary/Self-Reported Overpayments by the Provider:
If a provider voluntarily self-reports an overpayment after the contractor issues a demand letter or a request for medical record, contractor will receive a discounted contingency fee. In order to be eligible for the contingency fee, the type and dates of service for the self-reported overpayment must be in the contractor’s most recently approved project plan. If the provider self-reports this kind of case to the contractor, the contractor must document the case in its files and the coordination system.

If a provider voluntarily self-reports an overpayment, and the self-reported overpayment does NOT involve the same types of services for which the contractor had issued a demand letter or a request for medical records, the contractor is not entitled to a contingency fee amount. If the provider self-reports this kind of case to the contractor, the contractor must notify the MDHHS-OIG contract manager. Contractor may continue recovery efforts since the overpayment the provider self-reported involved a different provider/service combination.

HMS Implementation Plan:
If a provider agrees with the RAC’s findings, they will be instructed in the Final Audit Report to correct the relevant claims in the MMIS/CHAMPS system within 30 business days. If the provider fails to correct the claims within 30 business days, HMS will notify MDHHS-OIG to void the claims, which are subject to recoupment. If the HMS’s finding was not a full recoupment of an individual claim, but an adjustment, it is the provider’s responsibility to resubmit a corrected claim to MMIS/CHAMPS. Instructions for resubmitting corrected claims will be provided in the Final Notice of Recovery Letter. These instructions must be followed to prevent timely filing rejections of resubmitted claim(s). If the provider disagrees with the RAC’s findings, but a resolution favorable to the State is reached as a result of the Pre-hearing Conference with the MDHHS-OIG or after an appeal to the ALJ, the rules stated in the previous paragraph with respect to correcting claims will apply.

HMS understands that provider adjustments may not be possible for all claims through CHAMPS. Upon notification from the provider that a claim cannot be adjusted, HMS will notify MDHHS-OIG so that a gross adjustment can be made. In cases where claims adjustment is not an option, HMS will work with MDHHS-OIG to establish acceptable alternative methods of recovery including recovering from current or future Medicaid payments, by check or as a last resort, through installment agreements. HMS will seek prior approval from MDHHS-OIG for all alternative methods of recovery.

HMS will ensure that written notification with appropriate language regarding the intent to refer is sent to the delinquent provider before the debt is 130 days delinquent. In such cases, HMS will cease all recovery effort. HMS will review each case to ensure that it is not exempt from referral and will provide MDHHS-OIG with all related documentation for review and approval prior to referral.
15. Provider Education

Description:
Education and outreach concerning the use of contractor, including notification to providers of audit policies and procedures, is the responsibility of the contractor. The contractor must educate providers on their business, their purpose and their process. MDHHS-OIG will approve all presentation and written information shared with the provider, beneficiary, and/or other debtor communities before use. If requested by MDHHS-OIG, the contractor’s project manager for the contract, at a minimum, must attend any provider group or debtor group meetings or congressional staff information sessions where the services provided by the recovery audit contractors are the focus.

HMS Implementation Plan:
HMS will use a variety of methods to reach out to providers and educate them. The methods may include written correspondence, telephone conference, newsletters, webinar or in-person during next provider onsite. HMS will maintain an Education Tracking Log file to keep records of the specific educations provided.

The RAC will, in consultation with the MDHHS-OIG, develop an education and outreach program.

The RAC shall post on its internet site its policies and protocols, as well as this Statement of Work.
16. Computer Support

**Description:**
The contractor shall ensure that it possesses the capability to provide computer programming that may be necessary to establish and maintain the data connection and interface with MDHHS-OIG.

**HMS Implementation Plan:**
HMS shall maintain a secure data exchange infrastructure to the MDHHS-OIG Medicaid Fiscal Agents.

HMS shall maintain in-place protocols to receive MDHHS-OIG RAC related data, including claims, and eligibility files weekly.
17. Data Security

Description:
The contractor shall purchase, maintain and configure an on-site firewall and work with MDHHS-OIG network staff to establish appropriate firewall rule sets. The contractor shall provide a written data security plan for approval by the MDHHS-OIG within 30 days of the Contract Award Date.

HMS Implementation Plan:
HMS possesses and maintains hardware and software firewalls to safeguard HMS and MDHHS-OIG data.

HMS shall work with MDHHS-OIG staff to ensure that appropriate firewall rule set is implemented.

HMS’s comprehensive data security program includes data management and storage procedures that will safeguard all information in whatever format we receive it (i.e., electronic transmission, tape, cartridge, CD, or hard copy).

HMS shall maintain appropriate access to project-specific, online data through a series of security controls and multi-level passwords.

SAS 70 Audit:
Each year HMS shall be subject to a comprehensive SAS 70 Type II audit conducted by an outside firm designed to ensure the MDHHS-OIG Contract Manager that HMS has the adequate controls and safeguards necessary to host and process data that we receive in the course of our ongoing service delivery—including the proposed engagement with MDHHS-OIG.

Data Confidentiality:
HMS shall maintain the security and confidentiality of all project-related data, files, and records in accordance with federal, state, and agency requirements, including:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Federal Regulation Code 42, Chapter IV, Subpart F, regarding the confidential nature of all information concerning Medicaid clients
- Computer Security Act of 1987, providing for a Federal Computer Standards Program, government-wide computer security, and training in computer security
- Privacy Act of 1974, Public Law 93-579 (4 U.S.C. 552a), regarding the design, development, and operation of a system of records on individuals to accomplish an agency function
18. Disaster Recovery

**Description:**
The contractor shall develop a Disaster Recovery Plan for restoring software, master files and hardware backup if information systems are disabled so that services are not disrupted. The Disaster Recovery Plan shall be documented for approval by the MDHHS-OIG Contract Manager and tested within four (4) weeks of the Contract Effective Date.

**HMS Implementation Plan:**
HMS disaster recovery plan is reported in Section 1.8.D.3 of Contract # 071B2200 proposal. HMS’s disaster recovery plan has been tested February 1, 2008, and annually thereafter.
19. Records and Documentation

**Description:**
The contractor shall maintain an audit trail within its case files for each claim. Copies of any contract-related documents in microform or digital image capture technology may be substituted for the originals with the prior written approval by the MDHHS-OIG.

**HMS Implementation Plan:**
HMS shall maintain an audit trail for each client, claim, and billing in hard-copy or MDHHS-OIG CONTRACT MANAGER approved electronic format.

HMS shall perform the following backups:
- Daily incremental backups, which include any changes to our system and control files
- Weekly full system backups, which include programs, operating systems, and control files

For any systems that run in a database, HMS:
- Log all transactions
- Perform incremental backups daily
- Perform full system backups weekly
- With respect to system data, HMS shall retain a copy of all processing outputs (e.g., billing files) in accordance with State requirements
20. Quality Assurance

Description:

1. Contractor must complete a Statement of Auditing Standards No. 70 (SAS 70) Audit. Contractor must contract with an independent and certified public accounting (CPA) firm to perform the audit. The CPA firm must have experience in Medicaid operations and must have experience performing SAS 70 Type II audits. A final report from the CPA firm must be submitted to MDHHS-OIG by the end of each award year. Any corrective action plan must be submitted to MDHHS-OIG within 45 days of the issuance of the final report.

2. At MDHHS-OIG discretion, MDHHS-OIG may perform a contractor performance evaluation. Advance notice may or may not be given. During the evaluation, MDHHS-OIG reviewers will work from a prescribed audit protocol, review actual cases and issue a final report. Any finding from the review will require a corrective action plan.

3. At MDHHS-OIG discretion, MDHHS-OIG may contract with an independent contractor to perform an accuracy audit on contractor’s identifications. At a minimum, this audit would be performed annually.

HMS Implementation Plan:

To ensure our clients that HMS has developed and continues to maintain the controls and safeguards necessary to securely host and process the data that we receive in the course of our ongoing service delivery each year, we have participated in the stringent Statement on Auditing Standards (SAS) 70 Type II audit. The SAS 70 Type II audit involves the CPA firm’s detailed testing of the organization’s controls over a minimum six-month period to ensure that they are suitably designed and that they operate effectively.

On June 15, 2011, the SAS 70 Type II audit was superseded by what is know as the Statement on Standards for Attestation Engagements (SSAE) No. 16 Service Organization Compliance (SOC) Type II audit. SSAE 16 is now the authoritative guidance for reporting on service organizations, and the SOC 1 Type II audit is even more rigorous than its SAS predecessor. It still covers a minimum six-month period, but the SSAE audit is more in line with international standards, and it requires a written assertion from company management concerning the design and operating effectiveness of the organization’s data system as well as its controls.

During an SSAE 16 audit, auditors conduct a thorough inquiry; observe, inspect, and test our controls; and issue a formal opinion. HMS’s performance in these audits will continue to ensure that our policies, procedures, and operational activities, including those for MDHHS-OIG demonstrate optimal standards for security, availability, and integrity.
21. Staffing

Description:

The following are a list of key personnel:

**Chief Medical Director** – one full time equivalent; consults with other key personnel when necessary; review medical necessity determinations

**RNs, Therapists, Healthcare Professionals** – perform medical necessity reviews

**Certified Coders** – perform coding determinations.

**Chief Medical Director**

HMS National Chief Medical Officer (CMO) at its corporate level will oversee the medical record review process for all RAC contracts for HMS. In addition to the CMO, HMS contracts with a panel of Medical Doctors in various fields of medicine who are available as needed. HMS will employ or contract with a part-time Michigan licensed Medical Director that will manage the panel of medical doctors, assist nurses, therapists, and certified coders upon request; manage quality assurance procedures; and maintain relationships with provider associations.

Chief Medical Officer

Relevant Work Experience

Prior work experience in the health insurance industry, utilization review firm or health care claims processing organization, extensive knowledge of the Michigan Medicaid program particularly the coverage and payment rules and public relations experience such as working with physician groups, beneficiary organization or Congressional offices.

Relevant Educational Experience

Experience practicing medicine as a board certified Doctor of Medicine or Doctor of Osteopathy in good standing with a licensing authority of a State within the US and is currently licensed.

Contractor must periodically verify that the license is current. When recruiting Medical Directors, contractor must give preference to physicians who have patient care experience and are actively involved in the practice of medicine.

Primary duties include:

- Providing the clinical expertise and judgment to understand Medicaid policy, federal and State rules and regulations;
- Serving as a readily available source of medical information to provide guidance in questionable claims reviews situation;
- Recommending when provider education, system edits or other corrective actions are needed or must be revised to address;
- Contractor vulnerabilities;
- Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;
- Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse.
- Provide national perspective and an understanding of Medicaid, health issues and practices.
Other duties include:
- Interacting with the Medical Directors at other contractors and/or contractor to share information on potential problem areas;
- Participating in Medical Director clinical workgroups, as appropriate; and
- Participating in Medicaid/Contractor presentation to providers and associations.

Michigan Licensed Physician

Relevant Work Experience
Prior work experience in the health insurance industry, utilization review firm or health care claims processing organization, extensive knowledge of the Michigan Medicaid program particularly the coverage and payment rules and Public relations experience such as working with physician groups, beneficiary organizations or Congressional offices.

Relevant Educational Experience
Experience practicing medicine as a board certified doctor of medicine or doctor of osteopathy in good standing with the Michigan State licensing authority and who is currently licensed.

Contractor must periodically verify that the license is current. When recruiting, Contractor must give preference to physicians who have patient care experience and are actively involved in the practice of medicine.

Primary duties include:
- Providing the clinical expertise and judgment to understand Michigan Medicaid policy, federal and State Rules and Regulations;
- Serving as a readily available source of medical information to provide guidance in questionable claims reviews situations;
- Recommending when provider education, system edits or other corrective actions are needed or must be revised to address;
- Contractor vulnerabilities;
- Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;
- Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse.
- Provide a local perspective and an understanding of Michigan health issues and practices.

To prevent conflict of interest issues, the Medical Officer and Michigan licensed physician must provide written notification to MDHHS-OIG prior to the appointment, election or membership effective date if the Medical Director becomes a committee member or is appointed or elected as an officer in any State or national medical societies or other professional organizations. In addition, Medical Directors who are currently in practice must notify MDHHS-OIG contract manager of the type and extent of the practice.

Staff Performing Complex Coverage/Coding Reviews
Whenever performing complex coverage or coding reviews (i.e. reviews involving the medical record), contractor must ensure that coverage/medical necessity review are made by an appropriate professional staff person, such as RNs, therapists, or healthcare professional whose expertise is in the field of medicine being reviewed, and that coding determinations are made by certified coders. Contractor must ensure that no nurse, therapist or coder reviews claims from a provider who is or was
their past employer. Contractor must maintain and provide documentation upon the provider’s request for the credentials of the individuals making the medical review determination. If the provider requests to speak to the Chief Medical Director regarding a claim(s) denial, the contractor must ensure the Chief Medical Director participates in the discussion. Medical necessity determination involving practitioners must be reviewed by a licensed physician or dentist with a like specialty.

**HMS Implementation Plan:**
HMS closely manages the assignment of claim review types, volumes and production goals to reviewers so as to not sacrifice the quality of the review. Throughout the contract term, HMS’s project team will leverage the resources of dedicated Michigan RAC team members as well as the expertise of our Subject Matter Experts (SME) throughout HMS. We will apply expertise and qualification from a broad range of specialized areas, including:

- Project Management
- Executive
- Regulatory and Reimbursement Research and Development
- Data Analytics
- Clinical Audit Services
- Financial Audit Services
- Provider Relations
- Information Technology

HMS’s expansive, nationwide resources and RAC service experience enable us to assemble a team for MDHHS-OIG that will apply both contract-specific and State-specific expertise on Michigan’s behalf.
22. Reports

**Description:**
The contractor shall generate the following project related reports in the format and schedule determined by the MDHHS-OIG.

- Monthly Administrative Progress Report
- Monthly Financial Report
- Monthly Vulnerability Report (included in Administrative Progress Report as Project Plan Update and Vulnerability issue identification)
- Final Report

The RAC must refer suspected cases of fraud and/or abuse (as defined in 42 CFR 455.2) to the MDHHS-OIG.

**HMS Implementation Plan:**
HMS will provide a comprehensive set of reports on a monthly, quarterly, annual, and ad hoc basis, as requested by the State. The information in these reports is maintained electronically, so report generation is timely and accurate.

**Meeting Summary Reports**
HMS will record and publish minutes of all meetings and conference calls related to the project, and we will distribute a summary of the meeting and agreed-upon next steps. Meeting summary reports will be delivered by secure email and will be archived and available electronically through the life of the contract.

**Monthly Status Reports**
HMS will prepare a *monthly administrative progress report* outlining all work accomplished during the previous month. These reports will include the following:

- Complications completing any task
- Update of Project Plan
- Update of what vulnerability issues are being reviewed in the next month
- Recommended corrective actions for vulnerabilities (i.e. system edit, provider education)
- Update on how vulnerability issues were identified and what potential vulnerabilities cannot be reviewed because of potentially ineffective policies
- Action Items
- Appeal Statistics
- Process Improvements to be completed by contractor

HMS will prepare a *monthly financial report* outlining all work accomplished during the previous month. This report must be broken down into eight categories:

- Overpayments collected – Amounts will only be on this report if the amount has been collected by MDHHS (in summary and detail)
- Underpayments identified and paid back to provider – Amounts will only be on this report if the amount has been paid back to the provider by MDHHS (in summary and detail)
Overpayments adjusted – Amounts will be included on this report if an appeal has been decided in the provider’s favor or if the contractor rescinded the overpayment after adjustment occurred (in summary and detail)

Overpayments in the queue – This report includes claims where the contractor believes an overpayment exists because of automated or complex review, but the amount has not been recovered by MDHHS yet

Underpayments in the queue – This report includes claims where the contractor believes an underpayment exists because of an automated or complex review, but the amount has not been paid back to the provider yet

Number of medical records requested from each provider (in detail)

Number of medical reviews completed within 60 days

Number of reviews that failed to meet the 60 day review timeframe and the rationale for failure to complete the reviews within 60 days

All reports must be in summary format with all supporting documentation.

Each monthly report must be submitted by the close of business on the fifth business day following the end of the month by email to the MDHHS-OIG Contract Manager and is to include the contractor’s voucher. All report formats must be reviewed and approved by the MDHHS-OIG Contract Manager.

**Final Report**

The final report must include a synopsis of the entire contract period. This includes identifying all amounts identified and demanded, all amounts collected and all amounts still outstanding at the end of the contract. It must include a brief listing of all identification methods or other new processes utilized and their success or failure.

Contractor should include any final thoughts on the program, as well as any advantages or disadvantages encountered. From a contractor point of view, the final report should determine if the contract was a success or a failure and provide support for either opinion. A final report must be delivered to the MDHHS-OIG Contract Manager in electronic format, as one file in Portable Document Format (PDF).

Drafts of all documentation must be provided to MDHHS-OIG approximately six weeks prior to final deliverable due dates unless otherwise agreed to. MDHHS-OIG staff will review materials and provide comments back to the contractor within three weeks, thereby allowing three additional weeks for the contractor make any necessary revisions.

**Fraud and Abuse Report**

HMS will refer suspected cases of fraud and/or abuse to the MDHHS-OIG immediately upon identification.
23. Definitions

**Appeal** – The process by which a decision or determination can be challenged.

**Community Health Automated Medicaid Processing System (CHAMPS)** – An online resource for Michigan Medicaid providers for claims processing and inquiry, member eligibility inquiry, provider enrollment, documentation submission, and prior authorization requests.

**Days** – Calendar days unless otherwise specified.

**Diagnosis Related Groups (DRGs)** – A patient classification system in which cases are grouped by shared characteristics or principal diagnoses, secondary diagnoses, age, surgical procedure, and other complications. Each DRG exhibits a consistent amount of resource consumption as measured by some unit (e.g., length of stay or dollars).

**Fee-for-Service (FFS)** – A method for reimbursement based on payment for specific services rendered to Medicaid beneficiaries. FFS applies to services for Medicaid beneficiaries who are not enrolled in Medicaid HMOs.

**Fraud** – Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law 42CFR 455.2. Patterns identified in the overpayments would be considered a red flag for potential fraud and necessitate a fraud referral.

**Medical Necessity** – Compliance with professionally developed criteria and standards of care determining that a patient warrants an acute hospital level of care for a given diagnosis and/or problem.

**Medicaid** – A program established to provide certain medical services to eligible low-income persons under Title XIX of the Social Security Act. The program is administered by states in accordance with federal statutes and regulations.

**Medicaid Beneficiary or Beneficiary** – An individual eligible for Medicaid who has applied for and been granted Medicaid benefits by the State of Michigan.

**Reconsideration** – A process that allows a physician to request the contractor to review additional documentation for the purpose of reconsidering an adverse determination.

**Retrospective Review** – A post treatment assessment of services on a case by case or aggregate basis after services have been performed.

**Technical Denial** - Denial of payment due to information not received from the provider within a specified period of time.