1. What is the look-back period for the RAC?
The look-back period is 3 years, based on the date of service.

2. What provider types should be prepared for a RAC review?
The scope of the Medicaid RAC includes all provider types.

3. What types of reviews will be performed by the RAC?
HMS may perform different types of reviews to identify potential overpayments, including:

**Automated/Semi-Automated Reviews**—Required when improper payments can be identified clearly and unambiguously from claim data elements and established Illinois Medicaid policies and rules, without examining medical records or other documents. These reviews are normally performed as a desk audit.
Complex Reviews—Required when data analysis identifies a potential improper payment that cannot be automatically validated through data elements and established policy and rules alone. The review requires the examination of records or other documents. These reviews are normally performed as a desk audit and will have records requests associated with them.

4. Can I submit records electronically?
Yes. HMS will accept provider submissions of records on CD/DVD or via fax. The initial page of the Medicaid RAC Audit Record Request Letter must be included with all documentation and CD/DVDs submitted to HMS. The standard procedure for submitting the password associated with the encrypted CD/DVD is to send the password (along with the first page of the Medical Record Request Letter) in a separate envelope from the encrypted CD/DVD (along with the first page of the Medical Record Request Letter). Please contact the HMS RAC Provider Relations Team at 1.855.699.6292 if you have questions.
5. How long do I have to respond to a review?

For **Automated (desk) Audits** providers will have 30 days from the date of the Preliminary Findings letter to request reconsideration. Once a Final Notice of Recovery has been received, a provider will have 60 days to request an appeal through IL HFS-OIG if applicable.

For **Complex (field) Audits** providers will have 30 days (beginning November 2016) from the date of the Record Request Letter to submit the appropriate documentation for review. Once a Preliminary Findings letter has been received, a provider will have 30 days to submit a request for reconsideration if appropriate. Once a Final Notice of Recovery has been received, a provider will have 60 days to request an appeal through IL HFS-OIG if applicable.

6. How long does the RAC have to audit after receiving documentation in response to a letter?

The RAC has 60 days to review records or documentation submitted for consideration.

7. Will extensions be allowed if delays occur in obtaining documentation needed?

No. Extensions will not be allowed during the RAC Audit process.

8. After I have received the RAC’s overpayment determination, may I ask for an additional review?

Yes. Providers can request reconsideration from the RAC and will be permitted to provide additional documentation relevant to the finding to support their assertion of correct payment under specified timeframes.

9. Will I have an opportunity to respond to the final audit findings report?

Yes. A provider will have 60 calendar days from the date of the Final Notice of Recovery to respond to a final audit findings report of an automated or complex review. Appeal rights notification and instruction will be included in the final audit findings notification.

10. What happens if I disagree with the final audit report?

The provider has the right to appeal RAC findings through standard IL Administrative Code hearing process. Hearing right notification and instruction may be found on the final audit report letter. This appeal should be submitted to HFS-OIG. HFS-OIG will notify HMS that a provider intends to dispute the finding.

11. If I file an appeal or ask for a hearing will I still have to pay back the amount of the overpayment in the final report?

If the provider files an appeal or asks for a preliminary conference, no recovery of the identified claim will occur until the appeal is resolved.
12. What happens if I fail to respond to a review?
Failure to respond to a review may result in the recovery (void) of all claims for which a response was not received.

When HMS identifies a potential overpayment, you will be notified of the identification of the overpayment in a preliminary findings letter. The related reasons for the overpayment will be provided in the Audit Detail. The preliminary findings letter will provide you with an opportunity to submit additional documentation if you have a reason to disagree with the finding. If you do not respond and notify HMS that you disagree with the findings by providing additional documentation/reasons in support of your position, based on the documentation available to HMS at the time of audit review, HMS may conclude the overpayment determination was accurate. Accordingly, HMS may determine an overpayment exists related to the claim. The overpayment amount will be referred to the State for administrative hearing, and you will be notified of the State’s Action and Intent to Recover the overpayment.

13. Can the RAC review a claim that was previously reviewed by a different auditing entity?
If the claim that was or is currently being audited by a state or federal agency or a contractor working for a state or federal agency involves the same issue or service then the RAC cannot audit the claim.

14. How does the RAC identify overpayments?
HMS identifies overpayments using Illinois Medicaid policy, legislation, and data.

15. Will the RAC identify underpayments?
Yes. HMS will identify claims where a potential underpayment occurred. The necessary back-up documentation for these claims will be requested and reviewed by HMS to validate the underpayment determination.

The RAC will not acknowledge underpayments self-disclosed by providers.

16. Will extrapolation be applied to determine the amount of overpayments?
At this time extrapolation will not be used for the RAC.
Frequently Asked Questions

17. How will overpayments be recouped?

If you agree with the final overpayment determination, providers must return a Payment Agreement (included with all Preliminary Findings and Final Notice of Recovery letters) to HFS-OIG indicating the method of repayment the provider is agreeing to; payment by Certified or Cashier’s check. Do not make payment adjustments once the audit commences. Providers are required to return the Payment Agreement to HFS-OIG.

Payment agreements should be sent signed and notarized to:

Illinois Department of HealthCare and Family Services
Office of Inspector General (HFS-OIG)
2200 Churchill Road
Building A-1
Springfield, IL 62702
Attn: RAC Payment Agreements

If you wish to reimburse HFS-OIG directly you may submit a Cashier or Certified check to:

Illinois Department of HealthCare and Family Services
Office of Inspector General (HFS-OIG)
2200 Churchill Road
Building A-1
Springfield, IL 62702
Attn: Collection Unit

18. Will the RAC provide education if I want to more fully understand the billing errors that resulted in an overpayment?

Yes. Each overpayment notice will include detailed description of the error with reference of the state policy, regulation, and/or guideline utilized to determine the overpayment. Additionally, education may be offered by written correspondence, telephone conference, or webinar, or in person.

19. Will providers be reimbursed for sending medical records?

No. There will be no reimbursement to providers for the copying/sending of medical records.

20. Will the appeals process change for the Medicaid RAC process?

No. The hearing appeal process for Illinois Medicaid RAC will not be changed from the current appeals process. The following link is to the Illinois Policy regarding the hearing appeals process. The best reference point is Title 89 Part 104, Subpart C with additional information found in Part 140.

Frequently Asked Questions

21. Is it also possible to change the point of contact for the Medicaid RAC Medical Record Request?

Yes. The point of contact can be updated by contacting Provider Services at 1.855.699.6292.

22. For clinical complex reviews does HMS rely on commercial clinical decision tools to validate admission decisions?

Yes. HMS will use Interqual Guidelines for accepted clinical criteria regarding admission status and level of care determinations.

23. Where should appeals be sent?

Appeals should be sent to:

Illinois Department of HealthCare and Family Services
Office of Inspector General (HFS-OIG)
2200 Churchill Road
Building A-1
Springfield, IL 62702
Attn: Appeals

24. Why do my calls to the Provider Services line go to voice mail?

The HMS RAC call center is programmed so that during high call volume times, a caller may wait on hold up to 5 minutes. The caller can choose to go to voicemail at any time, but after 5 minutes, the caller is routed to voice mail and prompted to leave a message. HMS encourages callers to leave a message. An HMS representative will return the call.

25. Can there be multiple provider contacts for my hospital?

There can only be one primary contact per provider/hospital. The initial one will be based off of the state files, but you can call into provider services (1.855.699.6292) to update that.

26. When is the Weekly Webinar cancelled?

The weekly Webinar will not occur if these holidays occur on a Monday:
- Martin Luther King, Jr. Day
- Presidents’ Day
- Memorial Day
- Independence Day
- Labor Day
- Christmas Day
- New Year’s Day
27. I did not bill Medicaid these claims, only Medicare?

This is likely a Medicare Crossover claim. When Medicaid providers submit claims to Medicare for Medicare/Medicaid beneficiaries, Medicare will pay the claim, apply a deductible/coinsurance or co-pay amount and then automatically forward the claim to Medicaid. Since Medicaid did pay, these claims are still applicable for RAC audit.

28. What if Date of Birth or other demographic information for the member is incorrect for the claim?

The information comes from the State of Illinois MMIS system. The information cannot be updated from a provider, and must be updated by the member. The member can contact their case worker or call the DHS Help Line at 1-800-843-6154 to update information from the application.

29. Will you accept passwords for CD medical records via email instead of phone?

Yes, please email: MDG-PSR-Password-DataNotify@hms.com. Please include: Provider Name, Letter Reference, Mail Date and Tracking number, along with the password information.

30. What are HFS’s timely filing requirements?

Timely filing is 180 days from the date of service. Medicare/Medicaid combination claims are allowed 24 months from the date of service. Please see HFS site for specifics: www.illinois.gov/hfs

31. I have a billing question that has to do with information outside the HMS audit.

You can call the HFS provider services department at 1-877-782-5565 or look at detail on the website: https://www.illinois.gov/hfs/MedicalProviders/Pages/default.aspx
32. Is there a website to check claim status?

You can call provider services at 1-(855) 699-6292 to check claim status. At this time, there is not a website to check claim status.

33. What is my appeal status?

Please wait at least 2-4 weeks before contacting anyone as it does take time for mail to be routed. The Appeals go through the Office of Inspector General who can be contacted at: HFS.OIG.RAC.Appeals@illinois.gov.

Please include: Contact Name, Contact Position, Provider Name, Provider Number, & claim number in inquiry.

It is very difficult to predict when the hearings will proceed, but the state will reach out to the provider in regards to next steps.

34. How do Installment Agreement Payments work?

If a provider chooses an Installment payment option, it is the provider's responsibility to send in the check monthly. Debtor shall submit a check payable to Healthcare and Family Services. 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.

35. Does a provider have formal hearing rights after preliminary finding?

No. After receiving the Preliminary Finding letter, if a provider disagrees, they can submit a rebuttal, or wait for the Final Notice of Recovery letter (if they choose not to pursue rebuttal). If the rebuttal is upheld, and after the Final Notice of Recovery letter, a provider can request an appeal formal hearing.