COLORADO
Department of Health Care Policy & Financing

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Recovery Audit Contract (RAC) Program Inpatient/Outpatient Rebilling Updates

Program Update RAC-0001 September 2023

Purpose & Audience

This program update explains the Recovery Audit Contract (RAC) Program's addition of an option for providers to rebill claims determined to be an overpayment based on a level of care (LOC) inpatient utilization review audit. For these types of inpatient audit finding the overpayment demand is for the full value of the inpatient claim. The provider type (01-Hospital) will be the most impacted by this program enhancement.

Background

HCPF contracts with Health Management Systems, Inc. (HMS) to conduct post-payment reviews of Health First Colorado (Medicaid) provider-submitted medical claims. As HCPF's vendor, HMS is contracted to collaborate with HCPF to determine whether medical claims paid to Health First Colorado enrolled providers were medically necessary, coded correctly, and properly paid.

The RAC program conducts utilization reviews of inpatient admissions which requires clinical staff at HMS to; review medical documentation, review claims data, apply CMS Medicaid inpatient only list(s), apply correct medical coding standards, apply Uniform Hospital Discharge Data Set (UHDDS) coding, and to use evidence-based utilization screening criteria, as required for inpatient reviews under 10 CCR 2505-10 8.300.12.A.2. In these audits, there is often no dispute that services were provided to Health First Colorado Clients in the identified medical claims, only that the services should have been provided in a more appropriate and cost-effective setting.

Inpatient Re-Pricing Limitations

For medical claims identified as an overpayment in this audit there is no way to determine the outpatient reimbursement of claims billed as inpatient initially, thus re-pricing is not an option. This is because the claims system reimburses inpatient on a prospective basis using All Patient Refined Diagnosis Related Groups (APR-DRG) methodology. By contrast, outpatient services are reimbursed using the Enhanced Ambulatory Patient Grouping (EAPG) methodology. Calculating outpatient reimbursement is highly discretionary because providers can choose to bill for different procedures, CPT codes and ICD's. As a result, it is unknown exactly what outpatient services a provider would have chosen when billing an outpatient claim.

Consequently, the best any post-payment reviewer can do is estimate what the provider may have billed if the services were provided in another setting. These estimations open the door to future disputes and operational disruptions. The only way to accurately determine what a provider would have billed and what their reimbursement would have been is to have the provider bill the services identified in the LOC audit under the EAPG methodology through the claims system. This is the most accurate way for providers to get correct payment for services provided to Health First Colorado clients.

Given this inability to presume how a provider might bill for outpatient services, HMS currently identifies the entire amount of the inpatient claim as an overpayment. HCPF recognizes, however, that in most instances, allowable services were provided.

Accordingly, HCPF is implementing the following changes to ensure that providers who receive an overpayment demand for claims identified through a LOC audit are able to receive the corrected value of those claims for any allowable services provided to Health First Colorado clients as if they were provided in the correct setting, such as observation or other outpatient setting. This is the process similar to that found in the Medicare RAC and Quality Improvement Organization(s) (QIO) LOC audits, part A to Part B rebilling.

Rebilling Options

As part of the ongoing enhancements to the RAC Program, HCPF is working to program the claims system with a permanent process to allow providers the option to rebill claims where the full amount of the claim is identified as an overpayment due to a LOC audit. Please note that ONLY overpayments that demand the full amount of a claim and that result from a LOC audit are subject to this rebilling process.

Option 1

Provider rebills LOC claims once they receive the initial overpayment notice

- Step 1: Medical records requested & reviewed
  - ✓ HMS determines if there is an overpayment
- Step 2: Overpayment Notice Sent
  - ✓ Notice sent to the provider identifying overpayment
- Step 3: Rebill
  - ✓ Providers request to rebill LOC audit findings
  - ✓ HCPF/HMS voids inpatient claims
  - ✓ Once voided, providers have 60-days to rebill outpatient claims

Option 2

Provider rebills LOC claims once they receive the informal reconsideration, overpayment determination notice

- Step 1: Medical records requested & reviewed

- ✓ HMS determines if there is an overpayment

- Step 2: Overpayment Notice Sent
  - ✓ Notice sent to the provider identifying overpayment
  - ✓ Providers request an informal reconsideration within 30-days from the date on the initial notice and send in additional documentation to HMS
- Step 3: Informal reconsideration determination
  - ✓ HMS reviews all documentation and either overturns or upholds the initial decision
  - ✓ Notice sent within 45-days after receipt of provider submitted informal reconsideration request
- Step 4: Rebill
  - ✓ Providers request to rebill LOC audit findings
  - ✓ HCPF/HMS voids inpatient claims
  - ✓ Once voided, providers have 60-days to rebill outpatient claims

If a provider disagrees with the findings in the original notice and/or the informal reconsideration determination, the provider can request a formal appeal of the determination before the Office of Administrative Courts (OAC). Appeals must be filed within 30 days from the notice. However, once appealed, it is the provider's position that the claim was properly billed as inpatient and that there are no allowable outpatient services available for that claim. Thus, the opportunity to rebill will no longer be available for those providers. Providers are encouraged to review overpayment notices for specific directions on their rights and responsibilities.

Pilot re-billing program and final implementation

To operationalize this rebilling process for providers HCPF is implementing system changes within the Medicaid Management Information System (MMIS) to allow providers to rebill medical claims in the claims system (interChange) after a Notice of Adverse Action or Informal Reconsideration Determination are issued. HCPF will be taking a phased approach to this implementation within the MMIS.

Phase 1

Status: Completed

This phase includes; the review of laws, regulations, risk assessments, research & guidance, plus any programming and staffing requirements

Phase 2

Status: Initiated

This phase includes; the rebill pilot program, posting of project charters and timelines, finalization of claims system programming, testing of programming with stakeholders, finalizing provider-centric operational instructions & drafting new notices

Phase 3

Status: Expected completion of 12/31/2023

This phase includes; posting of instructions, stakeholder engagement, provider training, monitoring feedback, and ongoing updates as needed

Implementing this rebilling process relies on many unique and new system requirements as well as transition and testing of the claims system. HCPF is committed to ensuring the process thoughtfully meets the needs of providers, as well as the needs of HCPF and of our Federal partners.

A Web-Based Training (WBT) will be available for providers to go over the new rebilling options and to go over the process for submitting claims. Quick guides will also be developed with our provider partners once programming and testing of they system has been completed.

For more information contact

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