**VA RAC Provider Outreach (Questions Log)**

**Q:** Is there a uniform resource locator (URL) for the VA RAC website?

**A:** [http://va.dmas.medicaid-rac.com](http://va.dmas.medicaid-rac.com)

**Q:** Is a copy of PowerPoint available?

**A:** PowerPoint presentation is available on the VA RAC website ([http://va.dmas.medicaid-rac.com](http://va.dmas.medicaid-rac.com))

**Q:** What claim dates can the RAC audit?

**A:** HMS shall not review claims that are older than three (3) years from the date of the claim.

**Q:** Can a provider export an Excel or a comma-separated value (CSV) file containing Provider Portal information?

**A:** Yes. Instructions will be provided with the Provider Portal User Manual.

**Q:** I have several practices in Virginia; will I need a provider log in for each practice?

**A:** If the practices are grouped under one NPI, they can be set up as a group. If the practices are NOT grouped under one NPI, the provider will be required to request access for the entire list of provider numbers involved.

**Q:** Will letters be sent to the practice address or billing address?

**A:** The initial letters will be submitted to the address provided by DMAS on their MMIS system, but this information can be updated via the portal or by a Provider Services Representative.

**Q:** Will the Provider Portal display the reason the claim has been selected for repayment?

**A:** Yes, the reason and the regulation source is included as part of the error description.

**Q:** What is the protocol concerning the number of claims selected at the time of review?

**A:** 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. Virginia DMAS may, at its discretion, amend the number of records requested on a particular project, to increase or limit the number of records.

**Q:** If the provider has fifteen (15) days to send in requested records, how long does HMS have to provide a preliminary report?

**A:** HMS must respond within 60 calendar days from the receipt of the documentation.
Q: How frequent are the request cycles?

A: The frequency of a cycle is dependent on the data received and the number of results yielded for each audit scenario but a typical cycle will be generated either monthly or quarterly based on decisions made by HMS and DMAS.

Q: Where in the process are HMS and DMAS in establishing review criteria with the Commonwealth of Virginia in order to begin the RAC audits? Is there a "Go Live" date?

A: HMS and DMAS are currently coordinating audit/review scenarios. The first set of audits was initiated on May 10, 2013.

Q: Will there be another webinar on this subject?

A: At this time, there is not another webinar scheduled.

Q: Will providers receive requests by certified mail? Some mail may get lost in sorting.

A: No, HMS will submit all letters through regular mail with a tracking number.

Q: Is the Provider Portal access based on group NPI or individual NPI?

A: Provider Portal access can be established by group or individual NPI; access will depend on the method in which the provider chooses to set up their provider portal access.

Q: Are the RAC audits in conjunction with other audits or is this in place of other audits?

A: The RAC is a separate audit contract and therefore will not replace any existing audits.

Q: Are we able to have more than one person signed up to use the Provider Portal?

A: Yes. Instructions will be provided with the Provider Portal User Manual.

Q: If you have a claim that was billed without the QW modifier as the example, is there a way to fix it or do we just have to refund?

A: This question should be directed to DMAS’ Provider Helpline, 1-800-552-8627.

Q: How will the provider portal be loaded initially and how do we communicate if we have an address specifically for audit requests for 1,200 providers?

A: The letters are addressed using provider information supplied by VA DMAS. Providers can enroll in the provider portal and have the opportunity to revise their contact information.
Q: The fifteen (15) day deadline does not appear reasonable based on the number of Medical records request we receive from other contractors. Can that be changed to thirty (30) days?

A: The current deadline to respond to a record request is fifteen (15) days from the date of the letter. This requirement is consistent with the time frame for DMAS’ other audit contracts. At this time, there is no intent to change the fifteen (15) day response deadline.

Q: After registering for the Provider Portal, will emails be sent to the provider when there is an audit/issue or will the provider be responsible for periodically logging into the Provider Portal?

A: Yes, there will be emails to alert that a cycle is available for viewing. If the provider experiences any issues, a contact number and email address will be available for assistance.

Q: If an under payment is discovered during an audit, should provider expect payment from Medicaid?

A: Recovery/collection/reimbursement efforts resulting from identified audit findings, including underpayments, shall be performed by Virginia DMAS.

Q: Where are the explanations for the codes?

A: An explanation of the codes will be provided with the Provider Portal User Manual.

Q: Does RAC apply to straight Medicaid or to VA Premier and Healthkeepers Plus also?

A: HMS will be auditing both in-state and out-of-state providers for the identification of underpayments and overpayments for all fee-for-service claims paid under the Medicaid and CHIP programs, for all medically necessary services for which payment is made by the Department under Titles XIX and XXI of the Social Security Act, and for any payment for services provided under the Code of Virginia Title 32.1, Chapters 10 and 13, as well as the Virginia Administrative Code, Title 12 Section 30.

Q: How often can records be requested, and what is the maximum number that can be requested each cycle?

A: Currently, there is not a limit to the number of records that can be selected for review. However, 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. Virginia DMAS may, at its discretion, amend the number of records requested on a particular project, to increase or limit the number of records.

Q: We are a personal care company. Is every Medicaid provider being audited?

A: Every Medicaid provider is subject to audit by the RAC.

Q: Can records be uploaded electronically to the Provider Portal?

A: At this time, records cannot be uploaded electronically to the provider portal however; the record request letter will state that the RAC will accept provider submissions of electronic records on CD/DVD, secure transmission or fax. The letter will also communicate the process for submitting the records.
Q: How many claims can be selected during each review process?

A: Currently, there is not a limit to the number of claims that can be selected for review. However, 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. Virginia DMAS may, at its discretion, amend the number of records requested on a particular project, to increase or limit the number of records.

Q: What if the provider has been previously audited for claims chosen for audit?

A: In order to minimize provider abrasion and maximize benefit to the Commonwealth, HMS shall coordinate all provider reviews with, the Virginia Department of Medical Assistance Services (DMAS), and any other appropriate state agencies to ensure no overlap occurs. The RAC may audit a claim that has been previously audited but cannot audit the claim for the same reason/service.

Q: How does a provider register for the Provider Portal?


Q: I am with a billing agency for VA Medicaid have four unique Tax ID numbers. Am I able to use the same login and password for the each of the four locations? Or will I have to have separate logins?

A: This can be set up as a group access and each location will be able to determine the claims associated with their location. Instructions will be provided with the Provider Portal User Manual.

Q: If we access the Provider Portal, will it change the start date of our thirty (30) day timelines or does the timeline begin when we receive the letter? Should we go by the date on the letter?

A: Accessing the Provider Portal will not change any dates. The dates on the letters should always be adhered to when completing an audit as the timeline begins on the date of the letter. The current protocol is to respond to the letter based on the timeline described in the letter.

Q: We are currently experiencing issues with Provider Portal availability and/or server problems. Is that being addressed?

A: To report a problem with Provider Portal, please call the HMS Help Desk toll free at 855-55HMSIT (855-554-6748) or send an e-mail to ecenterhelp@hms.com.

Q: What is the customer service number for HMS?

A: A provider may reach HMS Provider Services at (855) 791-1577.

Q: Is there any reason to sign up for the Provider Portal if you are not audited?

A: A provider may be audited in the future, but there will be no information for a provider to view until he/she is identified in an audit.
Q: Are the HMS physician review peers the same specialty as the doctors being audited?
A: HMS is in consultation with a variety of different specialty providers who will be consulted if necessary.

Q: Will HMS provide information regarding the main issues being audited?
A: Yes, the reason and the regulation source is included as part of the error description.

Q: Does HMS receive payment per audit or by wage? This is important.
A: Neither. The RAC is exclusively a contingency fee contract. HMS is paid the same fee to identify underpayments and overpayments.

Q: In past audits, all providers were audited. Will this process remain the same for the RAC or is it based on random selection?
A: The process remains the same. All providers are subject to audit through the RAC.

Q: Will DMAS send information on audited claims to facilities/providers through the remit process; specifically will we receive an informational adjustment on the remits prior to the actual retraction of monies?
A: Recovery/collection/reimbursement efforts resulting from identified audit findings, including underpayments, shall be performed by Virginia DMAS.

Q: When HMS requests documents, would a scanned copy qualify or would HMS require a physical copy of the document?
A: Scanned “legible” copies of the requested documentation will suffice and can be submitted via facsimile or mail.

Q: We have accounts where HMS determined the patient had primary insurance and VA Medicaid paid the claims as primary. HMS sent a letter and claim to the primary insurance and the primary insurance reimbursed VA Medicaid at the Medicaid rate. The problem with this process is the primary insurance carrier reimburse Medicaid at the Medicaid rate and the provider will have no recourse to be reimbursed by the primary carrier at the contracted rate the primary insurance has with the provider. Will HMS consider notifying the provider of the primary insurance to allow the provider to refund VA Medicaid and bill the primary insurance? This process will allow the provider to be reimbursed by the primary insurance at the contracted rate the provider has with primary insurance.
A: Medicaid is always intended to be the payer of last resort. Notifying a provider in advance that a patient has Third Party Liability Insurance (TPL) is not a RAC function.

Q: What does HMS and MMIS stand for?
A: HMS = Health Management Systems. MMIS = Medicaid Management Information System
Q: If a provider has never received an audit, will the provider be required to register with HMS now or wait until the first letter is received?

A: A provider can register by visiting https://ecenter.hmsy.com and following the User Registration instructions or HMS will send the initial letters to the address provided by DMAS on their MMIS system. This information can be updated via the portal or by a Provider Services Representative.

Q: If a provider appeals a denial, is he/she required to resubmit the clinical information to DMAS or will HMS forward the information?

A: The provider will be responsible for submitting the appropriate documentation to support their appeal to DMAS Appeals Division. HMS will be required to submit a case summary with the necessary documentation to support the recommended retraction.

Q: Are provider audits public? Where can we find current and past audit results on the website as a provider?

A: Current and past audits conducted by the RAC are not currently available on the RAC website.

Q: Can we obtain records requests and results letters from the portal?

A: Record requests can be obtained via the Provider Portal while results letters can only be viewed via the claims status reports as the codes change.

Q: Should all appeals be submitted directly to DMAS when appealing a finding?

A: All appeals should be submitted to the facsimile or mailing address indicated on the final overpayment letter. HMS will provide the DMAS fax number on the final overpayment letter.

Q: Can a provider fax appeals to DMAS?

A: All appeals should be submitted to the facsimile or mailing address indicated on the letter. HMS will provide the fax number on the provider audit letter.

Q: Can a report from the Provider Portal be generated and exported to excel to include the patient detail?

A: Yes. Instructions will be provided with the Provider Portal User Manual.

Q: Is this a new website/portal? Why are you providing information at this time? I've known about HMS for a long time, so I just wonder why we're getting this info now. Is this because the number of audits is being increase?

A: The HMS Provider Portal supports many HMS products. Each product has its own, unique, ID number and is unique to that program or product offering. Most of the features or functionality exists across our multiple products.

For VA RAC, there is a distinct Provider Portal site and data base, which supports the claims under review for this contract. A provider will need to register for unique access to manage the claims under audit for VA RAC.
Q: Due to date range of claims being reviewed, it is possible for our company to be audited for dates of service billed by the client’s previous billing company which is no longer in business. Claims that may be reviewed for Medicaid paying as primary when it should be secondary would result in our company’s inability to submit a bill to the previous carrier as they were not accounts we serviced. Because of this scenario would our client be responsible to just accept the result of the audit and recoupment or are there optional considerations for a scenario such as this?

A: To clarify, the RAC audits the service provider not the billing company. Changing of the billing company does not affect the audit of the claims. Medicaid is always intended to be the payer of last resort. Medicaid seeks reimbursement anytime it paid as the primary insurance when it should have been a secondary option. The provider’s inability to submit a bill to a previous carrier is not a function supported by the RAC.

Q: Will continuing education units (CEU) be provided for this webinar?

A: CEU will not be issued for this webinar.

Q: Is there going to be multiple appeal levels?

A: The RAC contract will follow the standard Virginia appeals process that includes an "informal" and "formal" appeal. Information on the "informal" and "formal" appeal process can be found in the Scope of Work link on the VA RAC website (http://va.dmas.medicaid-rac.com). It is under section 12. Record Review Periods and Appeals on page 18.

Q: What codes will be loaded onto the remit to identify this is a RAC account?

A: Invoices sent by DMAS’ Fiscal Staff will indicate PCP-RAC. Any additional questions contact DMAS’ Fiscal Accounts Receivable Unit, (804) 786-5433.

Q: Will RAC be auditing Consumer directed services or providers?

A: Consumer Directed Services are subject to audit.

Q: If an agency was audited by Medicaid for a quality assurance audit could they also be audited by RAC the same year?

A: Yes.

Q: Who will get the first letter if we have not set up contact on the provider portal?

A: The initial letters will be submitted to the address provided by DMAS on their MMIS system, but this information can be updated via the portal or by a Provider Services Representative.

Q: Will this be a different Provider Portal than the one we are currently using for HMS audits?

A: The HMS Provider Portal supports many HMS products. Each product has its own, unique, ID number and is unique to that program or product offering. Most of the features or functionality exists across our multiple products.

For VA RAC, there is a distinct Provider Portal site and database, which supports the claims under review for this contract. A provider will need to register for unique access to manage the claims under audit for VA RAC.
Q: If we shouldn’t register on the provider portal until we get our first letter, how will you guys know where to send the letters?

A: The initial letters will be submitted to the address provided by DMAS on their MMIS system, but this information can be updated via the portal or by a Provider Services Representative.

Q: What percentage or fee does HMS get paid?

A: HMS receives a contingency fee of 9.3%

Q: But emphasis is not on underpayments so again not fair...you are bounty hunters basically?

A: 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 report underpayments in situations where the provider failed to include a provided service on a claim and will it process or report underpayments self-disclosed by providers.

Q: How will HMS determine when a letter has been received by a provider?

A: HMS will submit all letters through regular mail with a tracking number. Additionally, Provider Services will perform an outreach five (5) days after mailing.

Q: How long before access to the Provider Portal becomes void? Can a Provider remain active by logging in occasionally or must there be two way communications?

A: The Provider Portal access will be disabled after thirty (30) days of inactivity. A provider may retain an “active” status by logging in periodically.

Q: If we have more than one office, can all offices be audited within the same year?

A: Yes.