COLORADO
Department of Health Care Policy & Financing

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Colorado Recovery Audit Contract (RAC) Claim Limits and Provider Tiers

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Background

The purpose of the claim limits and tiers is to create a manageable amount of claims that can be requested by the RAC vendor each month. The tiers align specific provider types, similar provider billing patterns, and similar provider staffing levels or resources available for compliance related activities. The requirement for claim limits is under the Code of Federal Regulations (CFR), §42 CFR 455.506(e). It requires that "States must set limits on the number and frequency of medical records to be reviewed by the RACs, subject to requests for exception from RACs to States." The tiers in Colorado are based on federal RAC standards from the Centers for Medicare and Medicaid Services (CMS) and CMS' approved methodology for our program in Colorado, specifically.

HCPF's Evaluation and Updates from 2012-2023

In 2012 HCPF created claim limits for medical records requests related to inpatient audits. These were based on a provider's reimbursements from the previous State fiscal year (SFY) 2011. These limits took into consideration the population of Health First Colorado (Medicaid) Clients we served at the time. Since 2012, the Medicaid population has increased from 700,000 Clients to 1.6 Million Clients (2023). This growth has also increased the quantity and reimbursement amounts billed per provider location/hospital facility. With increased claims being billed to Medicaid, we have to ensure that the minimum amount of claims reviewed is in compliance with the federal government's requirements.

HCPF has updated claim limits and tiers in the past 4 years when we do an analysis of these factors in order to fulfill these requirements. One such update we made in 2023 was related to automated audits, which do not have record reviews. However, HCPF did work with CMS to set up a max limit of claims which can be on a single "notice" (letter) that mirrored the federal RAC program. After an analysis of the automated audit volumes, HCPF adjusted the automated audit limits to create the same fair methodology for all providers that were initially only granted to hospitals. We can now ensure the amount of claims reviewed for a small provider is not at the same level of claims audited as a larger provider in these types of audits.

Defining Claim Limits & Tiers Methodology

Claim limits are the amount of claims that can be selected to be reviewed at one time. It also sets a limit on how often new claims or medical records can be requested, per provider location.

Tiers is the term used to define how we match common providers to their peers in terms of billing behavior and resources. This includes an analysis of:

- How many claims were billed
- What types of claims were billed (e.g. inpatient, outpatient, professional)
- The provider type (e.g. ancillary services, transportation, hospital)
- The value (monetary) of reimbursement to a particular provider for a singular state fiscal year (July 1-June 30)

A provider's location is defined by the service location. The identifier used to define the service location is the Colorado provider billing Medicaid ID. Any claims billed under this unique identifier are tied to the location where the service was rendered. Because the information in the claims system that is entered by providers does not indicate ownership or related facilities/locations, we do not have a reliable source of information to group providers in this manner. If the information is available in the future, we will do an analysis and may change the methodology. Providers would have to supply this information and keep it up to date to ensure accuracy of the claim limits.

While providers with multiple locations are not grouped together because of the lack of information provided, they still do have resources to lower administrative burdens, such as:

- Electronically submitting medical records and informal reconsiderations
- Receiving digital copies of all correspondence
- Selecting a specific address to have all correspondence mailed to
- Have multi-person access to all audit tracking and reporting

This is all available via the HMS Colorado RAC Portal.

As a note, the reason we have put such importance on providers keeping their information in the claims system up to date is related to the integrity of the data we use to do many functions within HCPF. Old identifiers that the provider may think are inactive, may still be active if they do not close out the ID. This can lead to errors in their billing where they unintentionally bill under an ID, causing claims to be selected for limits when there should be only one active ID for each location. This may go unnoticed if the payment (EFT) information is correct and the billing address is correct, but the billing Medicaid ID is not correct.

For more information and quick guides, please visit the HCPF website under "Provider Resources"

Colorado RAC Audits

The Colorado RAC has two distinct kinds of audits. Medical records reviews (complex audits) and data reviews (automated audits).

Complex Audits are reviews performed by clinical staff (RN/MD). In Complex reviews, clinical staff review the provider submitted medical documentation to substantiate services that were reimbursed to Providers based on the claims they submitted.

Automated data reviews are audits that use data to identify erroneously billed or coded claims. These audits are based on clear, publicly available guidelines and rules. Examples of automated audits are unbundling of medical codes or duplicate services billed for the same patient on the same date of service.

Colorado RAC Published Claim Limits & Tiers

In alignment with the federal RAC program, our claim limits and tiers are based on the audit type. As a note, the RAC has rarely, if ever hit a maximum of the limits they are allowed to audit. While there is a maximum, it does not guarantee a provider will be audited in that amount. We also want to note that in the highest tiers there are only a handful of facilities and most are in the middle and lowest ranges. We are working to publish these specific reports for the public in the coming year. For reference, our claim limits have been published on the HMS website since 2017.

Below are the descriptions of the four different claim limits and the tiers.

Automated Post Payment Reviews

The automated tiers have the following methodology:

- Claim limits are based on the previous state fiscal year's reimbursements to each specific provider billing Medicaid ID (location), ensuring providers are treated equitably
- This is then averaged to a monthly dollar amount of paid claims
- We then apply the limit to a tier, which is a percentage the average monthly dollar amount of paid claims
- All Automated Findings are mailed within the 3rd or 4th week of every month

Tier Name	Provider Reimbursement (Previous SFY)	Monthly Maximum Claims Limit Percentage
Alpha	$50 Million +	3.33%
Beta	$10 Million - $50 Million	2.92%
Gamma	$4 Million - $10 Million	2.50%
Delta	$1 Million - $4 Million	2.08%
Epsilon	Less than $1 Million	1.67%

Inpatient Complex Post Payment Reviews

The inpatient tiers have the following methodology:

- Claim limits are based on the previous state fiscal year's reimbursements to each specific provider billing Medicaid ID (location), ensuring providers are treated equitably
- Based on the total reimbursement to the provider they are placed in a tier
- Inpatient audits are mailed each month

Tier Name	Hospital Reimbursement (SFY 2021-2022)	Monthly Maximum Claims Limit
Alpha	$250 Million+	600
Beta	$69 Million - $250 Million	400
Gamma	$39 Million - $69 Million	200
Delta	$19 Million - $39 Million	100
Epsilon	$9 Million - $19 Million	50
Zeta	$1 Million - $9 Million	25
Kappa	< $1 Million	20
Sigma	Out of State Facilities	10

Hospice Complex Post Payment Reviews

The Hospice tiers have the following methodology:

- The same limit applies to All Health First Colorado Providers
- Hospice reviews are completed by reviewing the total of a patient encounter not a single claim for the patient
- The number of claims included in each case will be based on the claim submitted for a patient's episode of care billed by the provider
- Each case represents one (1) Health First Colorado member/patient
- Each case will have its own letter with a list of claims selected for that case
- A provider may receive up to 10 letters a month

- All letters will be mailed once a month during the 4th week of the month

Physician Administered Drugs (PAD) & Enterals Complex Post Payment Reviews

The PAD & Enterals tiers have the following methodology:

- The same limit applies to All Health First Colorado Providers
- The maximum claims that can be requested in a single month is 50
- All letters will be mailed once a month during the 4th week of the month
- A provider may receive a PAD review and Inpatient claim review in the same month

In the coming year we will be publishing training, discussing the topic in stakeholder meetings, reporting publicly on each provider and their claim limits (per Medicaid billing provider ID), as well as adding scorecards and peer reporting to the HMS Colorado RAC portal. When items are available, HCPF and HMS will be communicating availability to providers and stakeholders.

Colorado RAC audit information & training materials:

HMS Colorado RAC website
HCPF RAC Website
HMS Colorado RAC Portal Guide