School-Based Health Services Medicaid Briefing

RAC Audits: Understanding, Responding and Preparing for Future Audits

Presented by

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West Virginia Department of Education

May 7, 2025

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What is a Medicaid RAC Audit?

- A retroactive review of previously paid Medicaid claims conducted by Recovery Audit Contractors (RACs) to identify and recover improper payments. Medicaid RAC audits were established in 2010 and are often referred to as a government savings program.

- RACs operate under agreements with the Centers for Medicare and Medicaid Services (CMS) and are compensated on a contingency fee basis for recovered funds, with a national average of 12.5%.

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What is a Medicaid RAC Audit?

- The West Virginia Bureau for Medical Services has a contract with Healthcare Management Services (HMS) to conduct RAC audits.
- The “look-back” period for prior paid claims is up to three years.
- Example of “DEMAND” letter and claim audit detail next two slides:

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Cynthia A. Persily, Ph.D.
Cabinet Secretary

Cynthia Beane, MSW, LCSW
Commissioner

REVIEW RESULT: DEMAND

Date: March 6, 2025
Case Number: FAM-2025-02-00008-043

ATTN: Compliance Officer or CFO
ATTN: Correspondence Unit - Medical Records Department
[redacted] BOARD OF EDUCATION
[redacted] BOARD OF EDUCATION
[redacted]

Dear [redacted] COUNTY BOARD OF EDUCATION,

The West Virginia Department of Human Services (WVDoHS) Bureau for Medical Services (BMS) has retained Health Management Systems Inc., a Gainwell Technologies company, (HMS) to conduct periodic reviews of claims paid by the WVDoHS BMS for health care services to ensure the integrity of the paid claims, including coding validation, payment accuracy, compliance with regulations, policies, contractual requirements, and utilization standards. The information in this letter is CONFIDENTIAL and may contain Protected Health Information that may only be redisclosed in accordance with 45 CFR Parts 160, 162, and 164 (Standards for Privacy of Individually Identifiable Health Information and Administrative Requirements).

HMS has reviewed services provided to Medicaid members based on paid date.

Based upon the review of these claims, we have determined that the services billed were inappropriately paid. The amount of overpayment has been determined and is set forth in the attached Audit Detail listing the claim(s) reviewed, the disallowance that was made and the reason for the overpayment.

BMS requests that you remit the amount for inappropriate billings identified in the Audit Detail.

000290818K0000-PLHKZM00300029

AUDIT DETAIL

CONFIDENTIAL

This audit represents a RAC Audit. Claims subject to adjustment due to a RAC audit will be identified on your remittance advices with the following claim adjustment reason code: N432

Letter Date: 03/06/2025

Provider Number: PRZ0009902663 **Provider Name** **COUNTY BOARD OF EDUCATION** **Provider NPI: 1518155399**

Service From Date:	Service To Date:	Line #:	Claim Number:	Account Number:	Rev Code:	Proc Code:	Modifier Code:	Procedure Code Description:	Billed Amount:	Paid Amount:	Units Paid:	New Units:	Audit Message	Overpayment Amount:
Audit ID:	**305662**													
Patient ID/Name: WXMBR0000780323						**DOB: 12/28/**								
1/26/2022	1/26/2022	1	22187W000326	580010976		97150	GO	THERAPEUTIC PROCEDURES GROUP 2/> INDIVIDUALS	$238.04	$19.10	2	0	MUE (Medically Unlikely Edit)	$9.55
2/9/2022	2/9/2022	2	22187W000326	580010976		97150	GO	THERAPEUTIC PROCEDURES GROUP 2/> INDIVIDUALS	$238.04	$19.10	2	0	MUE (Medically Unlikely Edit)	$9.55
2/23/2022	2/23/2022	3	22187W000326	580010976		97150	GO	THERAPEUTIC PROCEDURES GROUP 2/> INDIVIDUALS	$238.04	$19.10	2	0	MUE (Medically Unlikely Edit)	$9.55
3/2/2022	3/2/2022	4	22187W000326	580010976		97150	GO	THERAPEUTIC PROCEDURES GROUP 2/> INDIVIDUALS	$238.04	$38.21	4	0	MUE (Medically Unlikely Edit)	$28.66
3/9/2022	3/9/2022	5	22187W000326	580010976		97150	GO	THERAPEUTIC PROCEDURES GROUP 2/> INDIVIDUALS	$238.04	$19.10	2	0	MUE (Medically Unlikely Edit)	$9.55
4/6/2022	4/6/2022	6	22187W000326	580010976		97150	GO	THERAPEUTIC PROCEDURES GROUP 2/> INDIVIDUALS	$238.04	$19.48	2	0	MUE (Medically Unlikely Edit)	$9.74
4/13/2022	4/13/2022	7	22187W000326	580010976		97150	GO	THERAPEUTIC PROCEDURES GROUP 2/> INDIVIDUALS	$238.04	$19.48	2	0	MUE (Medically Unlikely Edit)	$9.74
4/27/2022	4/27/2022	8	22187W000326	580010976		97150	GO	THERAPEUTIC PROCEDURES GROUP 2/> INDIVIDUALS	$238.04	$19.48	2	0	MUE (Medically Unlikely Edit)	$9.74
5/11/2022	5/11/2022	9	22187W000326	580010976		97150	GO	THERAPEUTIC PROCEDURES GROUP 2/> INDIVIDUALS	$238.04	$19.48	2	0	MUE (Medically Unlikely Edit)	$9.74

Our signature below demonstrates our agreement that we consider the results final and we will not take any action to contest the results of this audit. The payor agrees that no further validation audit will be performed on this claim and immediate adjustment activity will occur.

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What is Denial Code N432?

- Remark code N432 on a claim detail or explanation of benefit (EOB) indicates an adjustment of the original claim based on a Recovery Audit.

- Common causes of Remittance Advice Remark Code N432:
  - Overlapping or “duplicate service” claims where the **same service** is billed by **two different providers** on the same date of service or treatment span.
  - **Lack of adherence to the National Correct Coding Initiative (NCCI)***.

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Red Flags: Accuracy of Auditing Methods

***Lack of adherence to National Correct Coding Initiative (NCCI)

- The WV Bureau for Medical Services Policy Chapter 538: School-Based Health Services dictates the procedure codes that can be billed, as well as the number of units each month or year, as applicable.
- School-Based Health Services providers receive a Fee-Schedule each April 1st from BMS with new rates associated with our approved billing codes. The Fee-Schedule also includes approved billing modifiers.

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Red Flags: Accuracy of Auditing Methods

***Lack of adherence to National Correct Coding Initiative (NCCI)

The Fee-Schedule also includes approved billing modifiers. For example:

- SE is a modifier used to indicate that a service or procedure is covered by a state or federal government program, such as WV Medicaid School-Based Health Services.
- The modifier GP added to a billed code indicates billing for Physical Therapy.
- The modifier GO added to a billed code indicates billing for Occupational Therapy.

Red Flags: Accuracy of Auditing Methods

***Lack of adherence to National Correct Coding Initiative (NCCI)

- *PT and OT use similar billing codes. **For SBHS**, the modifier GP or GO is used to indicate the provider type billing. This allows Gainwell Technologies' claims processing parameters to identify that we may be billing the same procedure code, but different treating therapists are providing the service, for separate therapeutic interventions.
- *For healthcare billing, modifier 59 is used to indicate two or more distinct, separate encounters or "unbundled" services – this is the NCCI Standard.*

2025 WV Medicaid Reimbursement Rates School Based Health Services (SBHS) - Direct Services
Rates Effective 04/01/25 - 03/31/26
FMAP - 73.84% effective 04/01/25 - 09/30/25
FMAP - 74.22% effective 10/01/25 - 03/31/26

TYPE	PROC #	Modifier	2024	2025
Speech	92507		$ 9.10	$ 9.10
Speech	92508		$ 2.50	$ 2.50
Speech	92521		$ 93.03	$ 101.38
Speech	92522		$ 78.01	$ 84.66
Speech	92523		$ 159.23	$ 173.31
Speech	92524		$ 77.03	$ 83.34
Speech	92567		$ 11.07	$ 11.68
Speech	92570		$ 22.64	$ 24.42
Speech	92583		$ 36.42	$ 40.87
Speech	92592		$ 16.80	$ 16.80
Speech	92593		$ 18.90	$ 18.90
*OT/PT	97032	GP or GO	$ 10.09	$ 11.15
*OT/PT	97110	GP or GO	$ 20.18	$ 22.03
*OT/PT	97112	GP or GO	$ 23.13	$ 24.42
*OT/PT	97113	GP or GO	$ 25.10	$ 27.60
*OT/PT	97116	GP or GO	$ 20.18	$ 22.03
*OT/PT	97140	GP or GO	$ 18.70	$ 20.70
*OT/PT	97150	GP or GO	$ 12.55	$ 13.54
PT	97161		$ 69.40	$ 75.37
PT	97162		$ 69.40	$ 75.37
PT	97163		$ 69.40	$ 75.37
PT	97164		$ 47.99	$ 51.75
OT	97165		$ 70.14	$ 77.23
OT	97166		$ 70.14	$ 77.23
OT	97167		$ 70.14	$ 77.23
OT	97168		$ 48.24	$ 53.08
*OT/PT	97530	GP or GO	$ 24.86	$ 26.01
*OT/PT	97533	GP or GO	$ 41.34	$ 44.59
Nursing	T1000	SE	$ 6.50	$ 6.50
Nursing	T1001	SE	$ 120.00	$ 120.00
Nursing	92950		$ 224.20	$ 238.86
TCM	T1017	SE	$ 14.35	$ 14.35
Personal Care	T1019	SE	$ 2.87	$ 2.87
Transportation	T2001	SE	$ 22.86	$ 22.86
Transportation	T2002	SE	$ 26.77	$ 26.77

TYPE	PROC #	2024	2025
Audiology	92555	$ 18.46	$ 20.97
Audiology	92556	$ 28.79	$ 32.38
Audiology	92557	$ 25.59	$ 27.60
Audiology	92562	$ 30.76	$ 34.24
Audiology	92567	$ 11.07	$ 11.68
Audiology	92568	$ 10.58	$ 11.41
Audiology	92570	$ 22.64	$ 24.42
Audiology	92571	$ 19.69	$ 21.76
Audiology	92582	$ 55.13	$ 61.31
Audiology	92583	$ 36.42	$ 40.87
Audiology	92587	$ 12.55	$ 16.45
Audiology	92590	$ 34.65	$ 34.65
Audiology	92591	$ 36.75	$ 36.75
Audiology	92592	$ 16.80	$ 16.80
Audiology	92593	$ 16.80	$ 16.80
Audiology	92594	$ 15.75	$ 15.75
Audiology	92595	$ 16.80	$ 16.80
Audiology	90832	$ 56.60	$ 63.17
Psychological	90834	$ 74.32	$ 83.34
Psychological	90837	$ 109.76	$ 123.41
Psychological	90839	$ 105.58	$ 118.63
Psychological	90840	$ 52.67	$ 58.12
Psychological	90846	$ 71.37	$ 80.15
Psychological	90847	$ 74.81	$ 83.60
Psychological	90853	$ 19.93	$ 22.56
Psychological	90791	$ 123.79	$ 133.23
Psychological	96110	$ 7.38	$ 7.96
Psychological	96130	$ 86.38	$ 93.95
Psychological	96131	$ 61.77	$ 66.08
Psychological	96136	$ 28.79	$ 31.32
Psychological	96137	$ 25.59	$ 27.07

 # Add GT Modifier for Telehealth

***Add GP modifer for PT**
*** Add GO modifer for OT**

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Red Flags: Accuracy of Auditing Methods

***Lack of adherence to National Correct Coding Initiative (NCCI)

- **The Gainwell billing portal does not accept Modifier 59 for our billing taxonomy (School-Based Health Services).**

- Again, modifier 59 is **the national billing standard** used to indicate that the provider acknowledges and certifies they have documentation to support applicable billing codes that would typically be denied on a claim. This includes scenarios such as group therapy and individual therapy treatments on the same day, or codes that would typically be bundled together, per National Correct Coding Initiative and CMS policy. These may be labeled MUE (Medically Unlikely Edit) on a RAC claim audit detail or NCCI.

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Red Flags: Accuracy of Auditing Methods

***Lack of adherence to National Correct Coding Initiative (NCCI)

- **However, this standard was applied by the HMS RAC auditors, which led to many of our audited claims being determined as improperly billed.**

Last Year, School-Based Health Services Audits Were Paused Temporarily

- Last school year, the WVDE Medicaid Coordinator contacted the WV Bureau for Medical Services, Gainwell Technologies Management and the Chief Integrity Officer at the WV Department of Human Services with concerns regarding the auditing standards.

- See next slide:

Additional Documentation Received:
01/26/2024

Original decision upheld

Reconsideration Review Summary:
HMS has selected the corresponding claim(s) through data analysis for potential incorrect Medicaid payments to providers billing on professional claim forms for procedure codes that generally should not be reported (billed) together. CMS NCCI Tables contain the list of code combinations "column one/column two" which identify the pay and deny codes. This table also has an indicator column which signifies whether or not the code combination can be overridden by a NCCI designated modifier. If a provider reports both service codes for the same member on the same day, the service that CMS has indicated as a "column two" code is denied and the "column one" code is eligible for payment.
Our audit is directed at ensuring provider compliance with applicable laws, regulations, rules, and policies of the Medicaid program as set forth by the applicable Florida Medicaid Provider Manuals, CMS, AMA, and/or CPT/HCPCS coding guidelines. After careful review of the documentation submitted, we have determined that the original finding is correct. Dispute Determination: Uphold.

If you have any que

***Our audit is directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid programs as set forth by the applicable FLORIDA MEDICAID PROVIDER MANUALS, CMS, AMA and/or CPT/HCPCS coding guidelines. After careful review of the documentation submitted, we have determined that the original finding is correct. DISPUTE DETERMINATION: UPHOLD

Follow Up: WVDE Medicaid Coordinator contacted RAC Auditor HMS and Gainwell Technologies to dispute the fairness of upholding a decision for WV based on Florida Medicaid Provider Manuals.

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RAC Audits Resumed in March 2025 with the same contractor, Healthcare Management Services (HMS)

- Several LEAs contacted me in early March to inform me they had received RAC audit DEMAND letters requesting repayment for improperly billed claims from 2022.
- After reviewing the audit details, I determined that the auditing parameters had not been changed, and our billing taxonomy was still not considered during this round of audits.

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RAC Audits Resumed in March 2025 with the same contractor, Healthcare Management Services (HMS)

- Communication was forwarded to the LEAs, advising them to contact Karen Finney at WVDE if their office received a **DEMAND** letter from HMS requesting repayment for improperly billed claims.

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RAC Audits Resumed in March 2025 with the same contractor, Healthcare Management Services (HMS)

- The WVDE Medicaid Coordinator has advised LEAs that identify incorrect billing to return the funds through future payment offsets.

  •This method of repayment allows for a paper trail and tracking of claims that have been settled by claim recoupment and is an HMS-approved method of repayment.

**Insert lesson learned the hard way example

West Virginia Medicaid Standard Repayment Agreement for All Overpayment Notifications

Provider Name:
Provider NPI:
Case Number:
Principal Amount of Repayment: $

Please select which of the following options you wish to use to repay the above overpayment. Sign, date and return this form.

- ☐ Check remittance for the full amount of the disallowance within 60 days of receipt of repayment date notification.
- ☐ Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment.
- ☐ A recovery schedule over _____ months (not to exceed (12) months), through (select one method below):
  - ☐ Monthly check remittance. or;
  - ☐ Monthly deductions from future claims.

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as an image transaction. **For inquiries, please call 1-866-243-9010**.

When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution.

This form must be returned to Bureau for Medical Services, Office of Program Integrity, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3710 no later than thirty (30) days after the date of this notification. If it is not returned, the Bureau for Medical Services will establish a lien against all future Medicaid payments until the overpayment is recovered in full and take any other necessary actions to assure recovery. Checks should be made payable to the Bureau for Medical Services.

_____ _____
Signature Date

Provider Name: _____ Overpayment Amount: $ _____

Provider NPI: _____ Amount Remitted: _____

Case Number: _____ Check Number: _____

Make checks payable to: **Bureau for Medical Services**

Please mail to: **Bureau for Medical Services**
Office of Program Integrity
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3710

edited 10/28/2023

ENSURE ACCURATE PROCESSING
PLEASE INCLUDE THE **CASE NUMBER** ON YOUR CHECK
AND ENCLOSE THIS VOUCHER WITH YOUR CHECK

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Next Steps:

- On April 29, 2025, WVDE received a call from HMS Regional Director, Michelle Hayes. Ms. Hayes apologized for the delay in response from Gainwell regarding our concerns and acknowledged our claims had been audited incorrectly due to a **"gap in their data mapping".**
- Ms. Hayes advised that she would be reaching out soon to report that the auditing parameters have been corrected.
- Please note that the audits *WILL NOT* stop, as they are *federally mandated for all provider types receiving Medicaid funding*.

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Next Steps:

- Please continue to monitor for DEMAND letters from HMS. We are required to respond either by submitting a Request for Reconsideration or by arranging payment for claims that have been reviewed and identified as improperly billed.

- Until we receive notice that our auditing parameters have been updated, LEAs should continue to use the Request for Reconsideration letter/template prepared by Karen Finney, Medicaid Coordinator. LEA staff will need to gather the requested documents to support the claims billed.

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Next Steps:

- Please reach out to Gainwell Provider Services for archived Remittance Advice and any other documentation requested by the auditors in the **DEMAND** letters.
- If your biller needs assistance in determining if there is an issue with their claims, they should contact me to schedule a time to review their claims and billing.
- Remember, Medicaid billing is COMPLEX, and occasional mistakes are inevitable.

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Additional Information and Advice:

- Staff should take the audits seriously, ***as they can be a valuable tool for identifying areas for improvement or potential issues in billing and claiming.*** However, they should not be intimidated by the notices. Every provider type across the country receives them.
    - *Insert $20,000 lesson learned the hard way narrative regarding the importance of staff communication and supporting documentation** and my first Humana RAC Audit. Therapy vs. Aide.*

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Additional Information and Advice:

- Please advise staff to begin working on the requested documentation and reviews as soon as possible.
- We do not want our funding recouped due to a failure to respond within the **30-day** timeframe requested by the auditors.
- Reaching out to me in a panic mode three days before the deadline will not help prevent recoupment after issues with our audit parameters are resolved. Money could be taken back on a technicality due to lack of response and supporting documentation.

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Additional Information and Advice:

- Ensure that your Medicaid administrative staff have your current address on file with Gainwell. Some letters are being sent to individual providers, old RESA addresses, etc. I have uploaded a change of address form on my Medicaid TEAM page.
- WVDE created a Medicaid TEAMS page that has policy, forms, manuals, announcements, and more. Please remind your staff the resource is available.

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Additional Information and Advice:

- The Remittance Advice from Gainwell, which matches your monthly EFT deposits for billed claims, will indicate any recoupments or offsets by HMS. The claim for which payment is being recouped will be indicated on the remittance advice.

- *As a best practice, someone such as a biller or other administrative staff should regularly review these for communications from Gainwell, the BMS-contracted Medicaid Management Information System.* The Remittance Advice Remark Codes (RARC) are an important way to identify billing errors causing denials or issues, which may help reduce future RAC audit findings.

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Additional Information and Advice:

- Important to remember: The RAC audits are completely separate from the regular Medicaid Documentation Compliance Audits performed by Acentra.

- Acentra is an independent contractor that reviews claims paid for a 90-day retroactive period and requests documentation required per Medicaid policy (BMS Chapter 538 – School Based Health Services). This includes documentation to support the services billed such as the IEP, proof of professional (Direct Service) staff credentials, staff licenses and certificates (CPR and first aid certification), consents to bill, physician authorizations (as applicable), and the plan of care.

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Additional Information and Advice:

- Acentra will complete the audits for the 2022 dates of service in December 2025. Thus far, the results from this audit cycle have been very positive, with multiple LEAs having no weaknesses noted in their supporting documentation.
- LEAs with claims identified as billed and paid without **proper documentation on file** will be required to reverse the claim in the Gainwell billing portal. The funds will be recouped on the next monthly remittance.

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Final Comments and Q&A:

- I have enjoyed my first year with the WV Department of Education and hope that your Medicaid teams have found me approachable and available to help. Medicaid billing is complex, and mistakes will inevitably occur, but together we can identify areas for improvement, develop strategies and move forward with a plan to do better!

- I must admit, I was not fully prepared for the steep learning curve presented by School-Based Medicaid billing and policy, especially Random Moment Time Study and Cost Settlement. However, I've dug my heels in and worked diligently to observe and learn ways to support the schools and children in my home state.

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Final Comments and Q&A:

- I will ***ALWAYS*** be looking for ways to improve our Medicaid program, assist LEAs, and most importantly, ensure that we are not leaving money on the table. You can trust that I am committed to making our program as effective and efficient as possible. Thank you.

Additional Questions?

Please feel free to email or call me anytime with questions about anything Medicaid-related or to schedule time for your staff for additional discussion and training.

Thank you for your time. I look forward to assisting your LEA in discovering strategies to grow its Medicaid revenue.

Karen Finney
WVDE Medicaid Coordinator
karen.finney@k12.wv.us