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11600. BACKGROUND

Claims processing (CP) procedures begin when a provider's claim is received by the State Medicaid agency or its fiscal agent. Decisions are made as to whether or not payment will be authorized and, if so, the dollar amount of the payment. In order to make these decisions, the claim is processed in accordance with established State CP procedures and requirements. Although different from State to State, some basic procedures are common to all States.

The claim is examined to insure that:

1. It contains all the required information;

2. the information is internally consistent;

3. the recipient who received the service and the provider who submitted the claim were certified as eligible to participate in the program on the date(s) of service;

4. the service provided is covered under the program;

5. the service does not exceed frequency limitations;

6. any required prior authorizations or certifications were obtained.

If the claim conforms to these requirements, a decision is made as to the dollar amount to be paid. This amount is determined by appropriate fee schedules and fiscal policies.

The Claims Processing Assessment System (CPAS) is a State administered Medicaid Quality Control program which serves as a management tool for examining and evaluating the accuracy of claims processing and payments. Federal monitoring of State CPAS activities is accomplished through management reviews in either the System Performance Review (SPR) for certified MMIS States, the State assessment for non-MMIS States, or other Federal review. These reviews are used as the mechanism to determine which CPAS; (i.e., alternate or mandatory/superior) a State must operate subsequent to the review period.

11601. OVERVIEW OF CPAS

A. General.--All States are required to operate claims processing assessment systems that have the capability to perform the following functions:

1. Identify deficiencies in the claims processing operations;

2. measure the cost of deficiencies;

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3. provide data to determine appropriate corrective action;

4. provide an overall assessment of the State's claims processing or that of its fiscal agent;

5. provide for a claim-by-claim review where justifiable by data; and

6. produce an audit trail that can be reviewed by HCFA or an outside auditor.

The above functions have been shown by demonstrations to be essential to an efficient CPAS plan. States with demonstrated superior performance may establish alternate claims processing assessment programs, subject to HCFA approval based on effectiveness, efficiency and economy.

B. Alternate System.--States whose claims processing systems are not affected by C below are allowed to operate an alternate claims processing assessment system using the methods of their choice subject to Federal criteria and approval. The alternate system could be an in-house independent audit, or an alternate quality control system. Any such system is subject to Federal approval prior to implementation. The required reporting for these States is minimal. States are not required to submit detailed samples. However, these States will be required to provide a report of the results of such assessments. (See §11606.)

C. Mandatory System.--A mandatory system, or a system that is judged superior, would be required of those States that:

1. Exceed a claims processing performance threshold. The threshold has been established as a payment error rate exceeding 1 percent and where misspent Federal funds annually exceed $1 million;

2. Make significant system changes (MMIS States only). A significant system change is defined as the replacement by an MMIS State of an approved claims processing subsystem, which must meet the conditions for initial approval of the MMIS; or,

3. Change system operators or fiscal agents and HCFA review determines that the performance of the CPAS in use does not adequately monitor the quality of the claims processing system during the transition.

The scope of the review process, documentation, development, and reporting requirements for the mandatory system are more comprehensive than for an alternate system. (See §11604.)

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D. Superior System.--A State required to operate the mandatory CPAS must use this system or a system determined by HCFA to be superior. A superior system provides better data, more data, or comparable data at greater efficiency or economy. States could, for example, use additional strata, review denied claims, conduct special studies in problem areas, or increase automation.

E. Definitions.--The following definitions are for use within the context of the CPAS.

Certified Provider Listing.--An official State registry of providers and facilities authorized to receive reimbursement for services provided to State Medicaid recipients.

CFR.--Code of Federal Regulations.

Correct Payment Authorization.--The lesser of either the amount billed by a provider for a covered service or the amount specified for that service in the appropriate payment fee schedule (fee schedules, reasonable charge profiles, etc.).

Dollar Error.--An error that resulted in an erroneous payment authorization; i.e., an overpayment, underpayment, or total dollar error.

Medicare Crossover Payment.--Payment authorization by the State Medicaid agency for the Medicare deductible and coinsurance amounts.

Overpayment.--A dollar error in which the payment authorization amount is in excess of the correct payment authorization.

Payment Authorization.--The amount adjudicated for payment by the CP operational unit regardless of the amount of the check subsequently issued to the provider.

Payment Fee Schedule.--A listing of the maximum payment rates for specified services covered under the State's Medicaid program.

Permissible State Practice.--Written procedures, provider guides, office instructions, and policy manuals and issuances that are consistent with the State plan or with approvable State plan amendments which have been submitted to but not yet acted upon by the HCFA RO.

Prior Authorization.--Prior approval by the State agency to reimburse a provider for a specific service, if rendered.

Procedural Error.--An error that occurred during claims processing which may or may not result in a dollar error.

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Recipient Paid Claim History File.--A listing, over a period of time, of medical services received by a recipient for which Medicaid reimbursement was provided.

The listing should provide the information necessary to conduct the QC review; e.g., the service rendered, units of service, date of service, provider of the service, date and amount of payment authorization, third party payment data.

Sample Unit.--A line item(s) representing the lowest level of payment adjudication for claims authorized for payment or adjustment. The most detailed claim breakdown for which a payment/adjustment determination is made and authorized. For purposes of the CPAS Manual, a sample unit is referred to as a "claim" in narrative discussions.

Total Dollar Error.--An error in which the full amount or part of the claim should have been disallowed; i.e., no portion of the payment/adjustment should have been authorized.

Underpayment.--A dollar error in which the payment authorization is below the correct payment authorization amount.

11604. MANDATORY SYSTEM

The mandatory system sample universe consists of all claims authorized for payment or adjustment by the State agency or its fiscal intermediary. Claims are subject to sample selection for the month in which payment is authorized rather than in the month in which the service was provided or in the month in which payment was actually made to the provider. Adjustments that increase or decrease previous payment authorizations are also subject to sample selection and review. However, claims for which no payment was authorized; i.e., denied claims, are not subject to sample selection.

The mandatory system provides data on the incidence of claims processing errors and the resulting cost of the errors in program dollars. Once a claim is selected, it is reviewed to determine (1) if it was processed in accordance with the State's CP procedures and (2) if the payment/adjustment amount authorized is correct. A CPAS Review Schedule is completed for each claim selected for review and is used to record information regarding the types and sources of errors found. The CPAS Review Schedule demonstrates a cause and effect relationship between occurrence errors and resulting dollar errors in the payment/adjustment authorization.

The mandatory system review is conducted in two major phases and produces two types of findings. In the first phase, the claim is reviewed to determine if it was processed correctly; that is, was all the necessary documentation present, were all the required procedures followed, were coding or data entry errors made, etc.? If processing errors were made, a procedural error is recorded on the CPAS Review Schedule. Procedural

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errors are described by nature codes and may or may not result in an incorrect payment/adjustment authorization. (The CP operational unit may make errors in processing the claim but the payment authorization may still be correct.)

In the second phase the reviewer must develop any procedural errors found to determine whether they caused the payment authorization to be incorrect. Development means that the CP reviewer must obtain missing documentation, rework payment computations, or perform other activities necessary to determine if the payment authorization was correct. If incorrect, a dollar error is cited on the CPAS Review Schedule. Dollar errors are described in terms of the nature of the error, type of the error (underpayment, overpayment, etc.), and amount of the error. A dollar error finding is recorded on the CPAS Review Schedule with the procedural error which was most responsible for the dollar error. As a result, statistical data is generated which describes the relationship between procedural and dollar errors in States' CP systems.

The mandatory system review is conducted in consecutive 6-month cycles. Each sample period represents one-half of the Federal fiscal year (from October 1 through March 31 and from April 1 through September 30). Based upon the State agency's completed CPAS reviews, HCFA-CO generates statistical reports and tables for each 6-month review period.

11604.1 Scope.--Claim payment authorizations and adjustments subject to sample selection are grouped by provider type. The claims selected for payments include the following groups:

o Inpatient hospital services (other than services for tuberculosis or mental diseases);

o long-term care services;

o other individual practitioners and clinics; and

o separately billed prescribed drugs.

The mandatory system review is concerned with the most detailed claim breakdown for which a payment amount was determined and authorized for payment or adjustment; i.e., the lowest level of payment adjudication by the CP operational unit. In many instances the claim under review (sample unit) will be a single service (office visit, drug, etc.) listed as a separate line item on the provider's invoice. (Other line items appearing on the same invoice not in the sample unit are subject to separate sample selection and review.) In other instances the sample unit may be several services listed separately on the provider's invoice but grouped together for payment determination purposes, or an inclusive rate payment made for an individual beneficiary (such as some hospital services, nursing home rates, etc.).

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For CPAS purposes, claims processing is considered complete when an authorization for payment has been made. The claim is reviewed for correctness based on the amount authorized. Adjustments (increases and decreases) made subsequent to the payment authorization are considered separate CP actions and are subject to separate sample selection and review. Adjustments may be in the form of a supplemental payment authorization, a debit or credit to the provider's account, or a new payment authorization after a credit to the provider's account for the amount of the original claim.

The review is not limited to the provider invoice information but includes examination of supporting documentation, recipient paid claim history files, payment fee schedules, and other source documents required to reach a definitive review finding. The review is conducted in accordance with State plans, State practice (provided there is no conflict with the State plan), and the review instructions contained in this manual.

A. Permissible State Practice and the State Plan.--The review is conducted in accordance with permissible State practice; i.e., written provider guidelines, office instructions, and policy manuals and issuances that are consistent with the State plan or with approvable plan amendments which have been submitted to but not yet acted upon by HCFA.

In all instances where State practice conflicts with the State plan (or approvable amendments) State practice is not permissible and the review is conducted in accordance with the provisions of the State plan. Although the State plan preprint is a simplified document, it is designed to be consistent with Federal regulations. Where the State plan does not specifically address an issue and State practice conflicts with Federal regulations, the review is conducted against the CFR. If, however, the approved State plan specifically addresses an issue but is in conflict with Federal regulations, the review is conducted in accordance with the approved State plan.

State plan amendments submitted to HCFA for approval but not yet acted upon are considered in effect for review purposes if the amendments are approvable. Plan amendments are approvable so long as they do not conflict with the CFR. Plan amendments which conflict with Federal regulations are not approvable and cannot be honored for review purposes. The effective date of an approvable amendment may be prospective or retroactive, but may not be retroactive beyond the beginning of the calendar quarter in which the amendment was submitted. If the effective date of the amendment is not specified, the date it is submitted to HCFA is the effective date for review purposes. Once submitted, an approvable plan amendment remains in effect unless it is formally disapproved by HCFA.

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B. Parameters of the Review.--Although payments and adjustments are subject to selection in the month of authorization, the review is conducted in accordance with policies, procedures, fee schedules, etc., in effect on the date(s) the service was provided or the date of payment authorization, as specified by permissible State practice. In instances where the service was provided over a period of days, particularly from one month to the next, it may be necessary to apply separate policies or fee schedules to the review when the dates of service span the effective date of a policy or fee schedule change. For example, one fee schedule may have been in effect for some of the services performed, but a different fee schedule became effective for the remaining services provided.

11604.2 Claims Not to be Reviewed.--Certain types of claims are not to be included in the mandatory CPAS sample universe. These will normally be eliminated in the sample selection process. Claims not to be included in the sample universe and considered listed in error if selected are:

1. Claims in which the payment authorization date is not within the sample month;

2. claims for which no Federal matching is claimed; i.e., are paid with State funds only;

3. claims that are an end-of-year institutional cost settlement;

4. claims that are 100 percent federally funded; and

5. claims listed under the incorrect provider type. (Claims included in the sample universe are stratified by provider type prior to sample selection options; i.e., hospitals, long-term care, individual practitioners and clinics, and prescription drugs.)

Due to the nature of the CP review and its documentation requirements, there are few valid reasons for not completing a correctly sampled case. For example, the absence of documentation is not a valid reason for an incomplete review. Reviews may be incomplete, however, when the State corrects for excessive oversampling in accordance with §11608.3.

11604.3. Review Completion and Reporting Requirements.--

A. Review Completions.-- Submit to the HCFA RO, on a weekly basis, a copy of the Review Schedule for each review completed during the week. As a guideline, complete a minimum of 90 percent of the monthly sample selection within 60 days after the close of

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the sample month. All CP reviews must be completed and submitted to the HCFA-RO by the end of the ninth month of the review cycle; e.g., June 30 for the October-March period and December 31 for the April-September period.

As a rule, State review findings are considered final when submitted to the HCFA-RO and may not be changed.

B. Reports.--States are required to submit monthly reports to the HCFA RO which contain sample selection data and disposition lists. Monthly reports are due to the HCFA RO within 5 working days after the end of the review month.

Using copies of the review schedules and the monthly reports, HCFA CO will generate status reports to monitor State completions and the 6-month statistical reports and tables.

States must also report claims and dollar universe figures by strata within 30 days after the end of the sampling period.

11604.4 Review Procedures.--The following sections outline the review steps, data needs and source documents, development, and error determination instructions for the claims reviews.

A. Steps in the Review.--As previously noted, the claim is reviewed in accordance with the State plan. In order to adequately meet the review requirements, the reviewer must have a thorough understanding of permissible State practice, the State plan, and a familiarity with the CFR. The reviewer must use this knowledge to:

1. Determine the policies and fee schedules in effect for the date(s) of service and/or the payment authorization date, whichever is applicable under permissible State practice;

2. determine the documentation required to process the claim;

3. determine if the unit followed the correct processing procedures; and

4. develop the review to determine if a correct payment authorization was made.

B. Below is a list of some of the specific steps which must be considered for each claim selected for review.

1. Payment for Services.--Check the invoice or paid claims file to determine:

a. If the claim was properly selected for review; i.e., was not listed in error;

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b. the line item(s) under review;

c. the review parameters established by the date(s) of service and/or payment authorization date; and

d. the amount of payment/adjustment authorization.

2. Provider Eligibility.--Compare the date(s) of service with the provider eligibility file to determine if the provider was, in fact, certified to participate in the program for the day(s) the service was rendered.

3. Recipient Eligibility.--Determine who the recipient was and establish that the recipient appeared on the Medicaid eligibility file for the month(s) covered by the date(s) of service.

4. Covered Services.--Compare the type of service provided with the services covered under permissible State practice to determine if the claim under review was for a covered service.

5. Required Invoice Information.--Determine if all required information was provided on the invoice. If not, develop missing information required to complete the review.

6. Appropriate Billing Procedures.--Determine if the provider followed the correct billing procedures when submitting the claim. Areas of consideration include, but are not limited to, compatibility of diagnosis and procedures, and inclusion of required support documentation (i.e., operative reports).

7. Prior Authorization.--Providers must obtain approval from the State prior to delivery of certain services if reimbursement is to be provided. Establish if prior authorization was required, if prior authorization was obtained and documented, and that the service provided was not in excess of any limitation set by prior authorization requirements.

Where the State provides for a waiver of prior authorization under certain circumstances, such as an emergency, verify that the waiver and subsequent authorization were granted or can be granted in accordance with permissible State practice. If a payment was approved without prior authorization, or waiver if provided for, a procedural error is cited. If prior authorization was not obtained and a waiver of prior authorization can not be granted, both a procedural and a dollar error must be cited.

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8. Level of Care Certification.--Where the State plan, or if not specified, permissible State practice requires evidence of certification prior to payment authorization, verify that the required certification was obtained. If not obtained prior to payment authorization, a procedural error is cited. Then determine if certification existed at the time of payment authorization. If certification at the time of payment authorization cannot be documented, a dollar error must be cited.

9. Duplication of Payment Frequency Restrictions.--Ascertain that a separate payment was not authorized for the service under review; i.e., the payment authorization under review does not duplicate a previous authorization. (Where a duplicate billing on a single invoice results in a duplicate authorization, the claim(s) appearing after the first claim on the invoice is considered a duplicate.) To determine if the sample unit is a duplicate payment authorization, compare the claim against a paid claims history which covers the period of time in which a claim can be submitted for payment as defined by permissible State practice.

In addition, determine whether a service was provided more frequently than allowed under permissible State practice. To accomplish this consider both the limitation on the number of times a service may be performed and any differences in the rate of payment for initial and subsequent services. Compare the claim against the claims history for the entire period of time the service under review is subject to frequency limitations under permissible State practice.

10. Authorized Payment Amount.--Verify the correctness of the claim amount authorized by consulting fee schedules, reasonable charge profiles, or by recalculating relative value based payments.

11604.5 Data Needs and Source Documents.--The reviewer is responsible for utilizing all documents and references necessary to determine if the claim was processed in accordance with required procedures and if the payment authorization was correct.

Source documents vary from State to State. For example, the original invoice, a photocopy of the original, or microfilm/microfiche may be utilized. Where the original invoice was submitted via electronic data transfer, a printout produced from the original transmission and containing all data relevant to the review is acceptable. Invoices are often annotated by State personnel during the various processing steps. The reviewer must ascertain if changes made to an invoice after submission by the provider could affect the error determination. Where the invoice has been altered during processing or where microfilming is not done prior to processing, it may be necessary to obtain the original hard copy invoice or verify key information via the provider's records.

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The following are examples of data needs necessary for review. Also listed are some of the source documents from which to extract the information.

DATA NEEDS SOURCE DOCUMENTS

1. Sample selection data; Listing of sample units

provider stratum and selected for review and

sample month. the State's sampling plan.

2. Invoices containing Microfilm/microfiche files;

the line items sampled. original or copy of invoice;

electronic data transfer

printout.

3. Payment Data. Recipient paid claim history

file; authorization for

payment.

4. Provider Eligibility Computer generated or

Status for Month(s) other listing of eligible

of Service. providers for month(s) of

service.

5. Recipient Eligibility Computer generated or

Status for Month(s) other listing of eligible

of Service. recipients for month(s) of

service.

6. Service Frequency Permissible State practice;

Limitations. recipient paid claim history

file; fee schedules; screens

and edits used in claims

processing.

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DATA NEEDS SOURCE DOCUMENTS

7. Allowable Payments for Specified fee schedules by

Services During the area; listing of payment

Service Date(s) or screens or edits used in

Payment Authorization claims processing; relative

Date. value scales (RVSs) for

services and conversion

factors (RVS multiplied by

conversion factor yields

fee); listing of "usual and

customary" charges by

provider group; hospital and

nursing home reimburse-

ment guides or manuals.

8. Services Covered by the Permissible State practice;

State Medicaid Program. drug guides; fee schedules;

provider reimbursement

manuals.

9. Prior Authorization Permissible State practice;

Requirements. fee schedules.

10. Requirements for Permissible State practice.

Physician Certification.

11604.6 Development and Error Determination.--

A. Development refers to the process of determining whether a procedural error resulted in a dollar error. All procedural errors are subject to development to the point necessary to determine the effect of the error on the payment authorization. Although all procedural errors are cited on the CPAS Review Schedule, development to determine dollar errors ceases at the point a total dollar error is found; i.e., the full amount of the claim should have been disallowed. Therefore, develop first those procedural errors found which could result in a total dollar error.

When development requires that the reviewer obtain documentation that was required, but missing when the claim was processed, the quality control unit will first contact the State operational unit to obtain the missing documentation. Examples of required documentation are:

1. The invoice containing the line item under review;

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2. prior authorization forms;

3. physician certification when the operational unit is required to verify certification prior to payment authorization.

If the State CPAS unit is able to supply existing documentation, and demonstrate that it was available when the claim was processed, no error will be cited. If the State CPAS unit must obtain new documentation; e.g., contact the provider, a procedural error is cited because the claim was processed without the required documentation. The correctness of the payment authorization is then reviewed based upon the new documentation.

If the operational unit fails to secure the required documentation, the State CPAS unit should obtain the missing documentation if possible. However, the ultimate responsibility and burden of proof rests with the State operational unit to demonstrate that the payment authorization was appropriate. If the required documentation cannot be obtained or is unacceptable, a dollar error must be cited. For example, if evidence of prior authorization cannot be obtained, it must be assumed that prior authorization was not granted.

Although the operational unit may obtain the necessary documentation, the CPAS unit must determine if the documentation is acceptable. Documentation which is acceptable in place of the original is:

1. A copy of the documentation from the provider's records;

2. a signed and dated statement from the provider containing the required data; or

3. a quality control reviewer's narrative of a telephone contact with the provider supplying the necessary documentation.

B. Error Determination.--The review measures the correctness of payment authorizations/adjustments by identifying claims processing errors and resulting dollar errors. Procedural errors occur during the processing of a claim and may or may not cause a dollar error. Dollar errors result in the payment authorization being in error, either a total dollar error, overpayment, or underpayment. A major objective of the CP review is to identify procedural errors and their effect on the correctness of the payment authorization. As a result, the nature of error codes for procedural errors are different than the nature of error codes for dollar errors.

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In making an error determination, first record all procedural errors found using the error code which best describes the nature of the procedural error. Then determine if the procedural error(s) resulted in a dollar error(s). If so, record an error code which best describes the nature of the dollar error.

Although the review is designed to establish a cause and effect relationship between procedural and dollar errors, the relationship is not always one-to-one. For example, the reviewer may determine that three procedural errors occurred during the processing of the claim, but that only one dollar error resulted. All three procedural errors are coded on the review schedule, but the resulting dollar error is only recorded once. In such instances, determine which procedural error most directly caused the dollar error.

11604.7 Error Category Profile

A. Nature Codes.--Nature codes are divided into seven categories under two major headings: procedural and dollar errors. Each category is divided into numerical subcategories describing the specific nature of the error. The specific nature of an error to be coded on the review schedule is the number of the error category and the number of the error subcategory which best describes the specific error. For example, a documentation procedural error cited because of no evidence of a claim would have the nature code 01.

B. Procedural Error Heading.--Procedural errors are divided into three categories: (1) Documentation, (2) Coding/Data Entry, and (3) Other Errors. Errors found in these three categories are recorded under the Procedural heading of the CPAS Review Schedule only and cannot appear under the Dollar heading.

Permissible State practice determines which subcategories of the Error Category Profile are applicable to the claim under review. When making the determination note that non-line item requirements associated with the adequacy of the invoice information; e.g., appropriate I.D. numbers, signature, are within the scope of the review and are associated with the appropriate procedural error category in the profile. Each procedural error found is to be recorded on the review schedule and is subject to development to determine if a dollar error also occurred. Since further development stops when a total dollar error is found, development should be completed first on those procedural errors most likely to result in a total dollar error.

1. Documentation.--Cite when a payment/adjustment is authorized without the information or verification required by permissible State practice. Each documentation error found is to be recorded and subject to development.

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CODE DESCRIPTION

01. No evidence of claim submittal (no invoice).

02. Physician/provider signature omitted or questionable.

03. Recipient signature omitted or questionable.

04. Required recipient identification missing or questionable.

05. Required physician/provider identification missing or questionable.

06. Referring physician identification missing or unclear.

07. Prior authorization missing or unclear.

08. Level of care certification missing or unclear.

09. Date(s) of service missing or questionable.

10. Diagnosis, procedure codes, and/or narrative description missing or questionable.

11. Number of services missing or unclear.

12. Drug type not specified or questionable.

14. Dollar amount of claim missing, unclear, or questionable.

15. Unauthorized force coding to bypass reasonable charge, fee schedule, or other edits.

19. Other required information/documentation missing, incomplete, or unclear. Use the reverse side of the CP Review Schedule to explain this error more fully.

2. Coding/Data Entry.--Cite when an error is made by the State agency in coding invoice or payment data, or in entering computer data. Each coding/data entry error found is to be recorded and is subject to development.

CODE DESCRIPTION

20. State entered incorrect code to identify noncoded recipient invoice data; e.g., recipient identification, sex type,

21. State entered incorrect code to identify noncoded provider invoice data; e.g., provider code,

22. State entered incorrect code to describe noncoded service data; e.g., procedure codes, drug type, billing codes,

23. State made keypunch error when transcribing coded data.

29. Other coding/data entry error not identified above. Describe on reverse side of review schedule.

3. Other.--Each of the following procedural errors found are to be recorded and are subject to development.

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CODE DESCRIPTION

30. Nonpermissible State practice - Written claims processing policy or procedure not in conformance with the approved State plan. (See §11604.1.)

39. Other procedural errors not cited above. This code is also used when a dollar error cannot be identified with a specific procedural error described above. Explain error fully on reverse side of the review schedule.

C. Dollar Error Heading.--Dollar errors are divided into four categories, (1) Eligibility, (2) Coverage, (3) Payment, and (4) Reasonable Charge. Errors found in these four categories are recorded under the Dollar heading of the CP Review Schedule. Since the review ends with the identification of a total dollar error, first develop those procedural errors which may result in a determination that the full amount of the payment authorization should have been disallowed. To assist the reviewer, probable total dollar errors are indicated on the Error Category Profile by an asterisk. Permissible State plans determine which subcategories of the profile are applicable to the claim under review.

1. Eligibility.--Cited when the provider or the recipient was not certified as eligible to participate in the Medicaid program during part or all of the service date(s).

CODE DESCRIPTION

\* 40. The provider was not certified as eligible.

\* 41. The recipient was not certified as eligible.

2. Coverage.--Cite when permissible State practice prohibits reimbursement for the service(s) under review.

CODE DESCRIPTION

\* 50. Service not covered under the permissible State practice.

\* 51. Service exceeded the frequency limitation. This code is used when the frequency limitation has been exceeded by the authorization for the payment under review.

\* 52. No required physician certification. Level of care certification requirements not met on service date(s).

\* 53. No required prior authorization. The State agency has not met required prior authorization requirements.

\* 54. Claim processed although the filing deadline had expired.

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\* 55. Additional EPSDT screening within prohibited time period.

\* 56. EPSDT screening service for a recipient age 21 or over.

\* 57. Inpatient charge includes both day of admission and day of discharge.

\* 58. Setup charges allowed although surgery was cancelled.

\* 69. Other coverage errors not specified above. Explain on reverse side of review schedule.

3. Payment.--Cite when a computation or payment determination error resulted in an incorrect payment authorization.

CODE DESCRIPTION

\* 70. Unable to verify that service was rendered.

\* 71. Duplicate payment authorized.

\* 72. Incorrect provider paid.

73. Copayment amount incorrectly applied.

74. Mathematical error resulted in incorrect payment authorization amount.

79. Other payment errors not specified above. Explain on reverse side of review schedule.

4. Reasonable Charge.--Cite when errors were made in applying reasonable charge rates, fee schedules, etc.

CODE DESCRIPTION

80. Incorrect reimbursement rate (fee schedule) applied.

81. New patient code used although claims history shows previous patient charge by the same provider.

82. Billed services improperly combined into service coverage package.

83. Payment authorized for more than one dispensing fee when a prescription was split by the pharmacist.

84. Payment authorized for drugs where the quantity prescribed is greater than the maximum quantity allowed by permissible State practice.

85. Payment authorized for a maintenance drug where the quantity prescribed is less than the minimum allowed by permissible State practice.

89. Other reasonable charge errors not specified above. Explain on reverse side of review schedule.

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D. Type Codes.--In addition to being described by nature codes, errors are also described by type. There are five error type categories:

1. No Dollar Error.--Procedural errors which, when developed, did not result in a dollar error. For example, the claim may have been processed without required documentation, but when the documentation was obtained it was determined that the payment authorization was in the correct amount.

2. Total Dollar Error.--Dollar errors in which the full amount of the payment authorization under review should have been disallowed; i.e., an overpayment in the full amount of the payment authorization. Development is ended after a total dollar error is identified.

3. Overpayment Error.--Dollar errors in which the payment authorization was in excess of the correct payment authorization amount.

EXAMPLE 1:

Dollar Amount Billed $15.00

Appropriate Reimbursement Rate $10.00

Dollar Amount Authorized $15.00

The overpayment error is the difference between the reimbursement rate and the amount authorized. The error amount is $5.00.

EXAMPLE 2:

Dollar Amount Billed $15.00

Appropriate Reimbursement Rate $25.00

Dollar Amount Authorized $25.00

In example 2 the overpayment is the difference between the dollar amount billed and the dollar amount authorized. Here the error amount is $10.00.

4. Underpayment Error.--Dollar errors in which the payment authorized is less than the correct payment authorization amount.

EXAMPLE 1:

Dollar Amount Billed $15.00

Appropriate Reimbursement Rate $10.00

Dollar Amount Authorized $ 5.00

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In example 1 the underpayment error is the difference between the reimbursement rate and the dollar amount authorized. In this example it is $5.00.

EXAMPLE 2:

Dollar Amount Billed $20.00

Appropriate Reimbursement Rate $25.00

Dollar Amount Authorized $10.00

In example 2 the underpayment error is the difference between the dollar amount billed and the dollar amount authorized. It is $10.00.

5. Nondeveloped Procedural Error.--Procedural errors which were: a) not developed to determine if they resulted in a dollar error, or b) resulted in a dollar error but the dollar error is assigned to another procedural error.

Code 5 is used to designate procedural errors which were not developed because the review was completed after identifying a Total Dollar Error or when several procedural errors resulted in the same dollar error. (Since the dollar error is coded with the procedural error most responsible, other procedural errors are coded as type 5 -Nondeveloped.)

11604.8 Special Review Circumstances.--

A. Third Party Liability.--Since TPL dollar errors are not within the scope of the CP review, no development of procedural errors is necessary.

B. Adjustments.--

1. Amount.--Only the net amount of the adjustment is under review. In most instances the adjustment amount is the full amount of the supplemental authorization, credit or debit. In other instances, if the initial payment was cancelled and a new payment authorized to the same provider, the adjustment is the difference between the original amount authorized and the new amount authorized; i.e., the net amount. For example, the original authorization in the amount of $20 was cancelled and a new payment authorized in the amount of $15. Although the $15 authorization must be reviewed for correctness, the amount of the adjustment reported on the CPAS Review Schedule is a $5 decrease.

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In instances where the original payment is cancelled and a new payment authorized to a different provider, the amount of the adjustment is the amount of the cancellation. The new payment authorization to a different provider is not considered part of the adjustment and is to be subject to separate sample selection.

2. Correctness.--In order to determine the correctness of adjustments, they must be reviewed in relation to the correctness of the original payment authorization and any prior adjustments. To be correct, the adjustment must be based upon an accurate assumption. For example, an adjustment may be authorized to increase an original payment. This assumes that the original authorization was less than can be allowed under permissible State practice. If, however, a review of the original authorization revealed it to be an overpayment, the assumption, and consequently, the adjustment are in error.

The original authorization must be examined as if it were the claim selected. That is, procedural errors are identified and developed in order to determine the correctness of the original payment authorization. The adjustment is then reviewed to determine if any original errors found, both procedural and dollar, were corrected or otherwise compensated for by the adjustment. If not, the errors carry forward to the adjustment and are coded on the CPAS Review Schedule. If, for example, a claim was originally processed without required documentation and the adjustment was processed without obtaining the documentation, a documentation procedural error is charged to the adjustment (unless, of course, the adjustment was to cancel the original payment authorization due to a lack of required documentation). Likewise, any dollar errors occurring in the original payment authorization, if not corrected in the adjustment process, may contribute to an adjustment dollar error.

The following outlines the types of adjustment dollar error findings which may result depending upon the correctness of the original payment authorization.

1. Original Authorization Correct and Paid in the Amount Specified in the Appropriate Fee Schedule.--

a. Adjustment to Increase.--Net amount of increase reported as total dollar error.

b. Adjustment to Decrease.--Net amount of decrease reported as underpayment.

2. Original Authorization Correct but Provider Billed Less Than Specified in Appropriate Fee Schedule.--

a. Adjustment to Increase.--Can be correct only if provider requests adjustment.

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(1) Net amount of increase correct if in amount of adjustment request or amount specified in the appropriate fee schedule, whichever is the lesser amount.

(2) Underpayment coded if net amount of increase is less than the correct adjustment amount as specified in (1) above.

(3) Overpayment coded if net amount of increase is more than the correct adjustment amount as specified in (1) above.

b. Adjustment to Decrease.--Net amount of adjustment reported as underpayment.

3. Original Authorization a Total Dollar Error.--

a. Adjustment to Increase.--Net amount of increase reported as total dollar error.

b. Adjustment to Decrease.--

(1) Any amount of decrease correct up to the amount of original payment authorization.

(2) Any amount of decrease beyond original payment authorization reported as an underpayment.

4. Original Authorization an Overpayment.--

a. Adjustment to Increase.--Net amount of increase reported as a total dollar error.

b. Adjustment to Decrease.--

(1) Any amount of decrease correct up to the amount of the original overpayment.

(2) Any amount of decrease beyond original overpayment amount reported as underpayment.

5. Original Authorization an Underpayment.--

a. Adjustment to Increase.--

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(1) Any amount of increase correct up to the amount of original underpayment.

(2) Any amount of increase beyond original underpayment reported as overpayment.

b. Adjustment to Decrease.--

(1) Net amount of decrease reported as an underpayment.

11604.9 Review Schedule Instructions.--

Complete a HCFA 331 CPAS Review Schedule for each sample unit selected for review.

SECTION I - CLAIM INFORMATION

Complete this section for each sample unit selected for review.

1-4. Optional State Use.--Enter claim or review information if desired. For example, recipient identification, reviewer identification, date assigned, date completed,

5. Local Code.--Enter the code, if applicable, that identifies the county or local agency that certified the recipient as eligible for Medicaid, or the fiscal intermediary that authorized the payment.

6. Sample Unit Number.--Enter the number (invoice - line item number) which identifies the sample unit selected for review.

7. State Code.--Enter the two-digit code for the State in which the review was selected. (See appendix A for State codes.)

8. Sample Month/Year.--Enter the month and year that corresponds to the specified sample month from which the sample unit was selected. States may specify a sample month other than a calendar month if their payment procedures operate on a fixed fiscal month basis. The sample month is specified in the approved State sampling plan.

9. Review Number.--Enter the number, alpha and/or numeric, assigned to the review. Enter zeros in any unused data positions.

10. Date(s) of Service.--Enter the date(s) of service covered by the payment authorization under review.

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FROM: Enter the first day of service (month/day/year) covered by the payment authorization under review.

TO : Enter the last day of service (month/day/year) covered by the payment authorization under review.

Where the service was provided during a single day, the "from" and "to" dates will be the same.

11. Date Payment Authorized.--Enter the date (month/day/year) the claim was authorized for payment.

If the date the claim was authorized for payment is not within the sample month, calendar or fiscal, the claim is listed in error.

12. Service Type.--Enter the code that identifies the type of service under review. (See appendix A for type of service codes.)

Service codes are divided into series 100-500 by provider type. Series 200, 300, and 500 are subdivided by types of service.

13. Claim Type.--Enter the number that corresponds to the type of claim selected for review. For adjustments it will be necessary to conduct the review before the appropriate adjustment code can be determined. (See §11604.8-Adjustments.)

(1) Original.--Enter the number one if the claim selected for review is the first adjudicated claim payment determination; i.e., the initial payment determination for an invoice prior to any adjustments.

(2) Adjustment to Increase/Original Authorization Correct.--Enter the number two if the claim selected for review is an adjustment to increase the amount of a previous correct payment authorization.

(3) Adjustment to Increase/Original Authorization Incorrect.--Enter the number three if the claim selected for review is an adjustment to increase the amount of a previous incorrect (over- or underpayment) payment authorization.

(4) Adjustment to Decrease/Original Authorization Correct.--Enter the number four if the claim selected for review is an adjustment to decrease the amount of a previous correct payment authorization.

(5) Adjustment to Decrease/Original Authorization Incorrect.--Enter the number five if the claim selected for review is an adjustment to decrease the amount of a previous incorrect (over- or underpayment) payment authorization.

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14. Amount Authorized.--Enter the amount authorized for payment or adjustment for the sample unit selected for review without regard to any subsequent adjustments to the payment amount. For adjustments, see section for explanation of amount authorized.

SECTION II - REVIEW DISPOSITION

Complete this section for each sample unit selected for review. Enter the number that corresponds to the disposition of the review.

1. Review Completed.--Enter the number one if a review finding is reached; i.e., item 15, is coded.

2. Listed in Error.--Enter the number two if the claim selected for review is listed in error. Use the space provided to explain the reason the claim is listed in error. The claim is listed in error if:

a. The date of payment authorization, item 11, is not within the specified sample month from which the claim was selected, item 8; or

b. the claim selected for review was denied; i.e., not authorized for payment;

c. the sample unit selected was listed on the wrong provider type sample listing prior to sample selection;

d. the sample unit selected is not a federally matched Medicaid claim; i.e., is paid with State funds only;

e. the sample unit selected for review is an end-of-year institutional cost settlement; or

f. the sample unit selected was 100 percent federally funded.

Incomplete.--Enter the number three if the claim was not listed in error but the review was not completed. (See §11604.2 - Claims Not To Be Reviewed.)

SECTION III - REVIEW FINDINGS

Complete this section for each sample unit selected for review that was not listed in error.

15. Findings Status.--Enter the number that corresponds to the findings status of the sample unit selected for review.

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a. Correct.--Enter the number one if no procedural or dollar errors were found during the review.

b. Procedural Error.--Enter the number two if only procedural errors were found during the review.

c. Procedural and Dollar Error.--Enter the number three if procedural errors resulting in dollar errors were found during the review.

16. Error Data.--Complete this item for each sample unit determined to contain a procedural or dollar error; i.e., number 2 or 3 was entered in item 15.

A. Procedural Errors - Nature. Enter the code from the Error Category Profile which best describes the nature of the procedural error found.

Record all procedural errors, working from the top to the bottom, identified during the review. If more than five procedural errors are identified, attach an additional review schedule in order to capture all procedural errors identified.

Develop each procedural error recorded to determine if it resulted in a dollar error.

Exceptions: TPL procedural errors are not developed. Secondly, if the development of a procedural error results in a Total Dollar Error (the full amount of the paid claim being overpaid), the review ends without the development of the remaining procedural errors. An overpayment or underpayment, however, does not end the review because subsequent errors may offset or compound the first error found.

B. Type.--Enter the number that corresponds to the type of the dollar error determination; i.e., no error, total dollar, overpayment, underpayment, TPL procedural, or nondeveloped procedural error.

1. No Dollar Error.--Enter the number one if the procedural error, when developed, did not result in a dollar error.

2. Total Dollar Error.--Enter the number two if the procedural error resulted in an overpayment in the full amount of the payment; i.e., the amount entered in item 14 should have been totally disallowed.

3. Overpayment.--Enter the number three if the procedural error resulted in an overpayment (the amount authorized was more than the correct authorization amount) but not in a total dollar error.

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4. Underpayment.--Enter the number four if the procedural error resulted in an underpayment; i.e., the amount authorized was less than the correct authorization amount.

5. TPL Procedural Error.--Enter the number five if the procedural error was a TPL error (code 13 or 31).

6. Nondeveloped Procedural Error.--Enter the number six if the procedural error was not developed (because a total dollar error was found) or although resulting in a dollar error, the dollar error was assigned to another procedural error.

C. Dollar Errors--Nature.--If the procedural error results in a dollar error, enter the code from the Error Category Profile which best describes the nature of the dollar error. If the procedural error is not developed, if development does not result in a dollar error, or if the dollar error has been reported (associated) with another procedural error, leave item C, Dollar Errors--Nature, blank.

After development of a procedural error, enter the dollar error data directly across from the procedural error; i.e., in line with the procedural error nature code.

Example -

Procedural Errors Dollar Errors

A. Nature B. Type C. Nature D. Amount

23 2 71 $ 000134 00

D. Amount.--If a 2, 3, or 4 is entered under item B, Type, enter the amount, in dollars and cents, of the error. If the number 1, 5, or 6 is entered in item B, item D is left blank.

The amount of a total dollar error is the full amount of the payment authorization under review. The amount of an overpayment or underpayment is the difference between the amount authorized and the correct payment authorization amount. The correct payment authorization amount is the amount specified in fee schedules or the amount billed, whichever is smaller.

17. Net Dollar Error Findings.--Complete this section if more than one dollar error was recorded in item 16-B.

A. Net Dollar Error Amount.--Enter the net dollar amount of all dollar errors combined. The net dollar error amount is determined by adding all overpayments together and subtracting all underpayments, and is the difference between the amount authorized and the correct payment authorization amount.

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B. Type.--Enter the number which corresponds to the type of the net dollar error finding.

1. No Net Dollar Error.--Enter the number one if overpayments and underpayments cancelled each other to result in no dollars being authorized in error.

2. Total Dollar Error.--Enter the number two if the net amount of all dollar errors results in an overpayment in the full amount of the payment authorization (item 16).

3. Overpayment.--Enter the number three if the net amount of all dollar errors results in an overpayment but not in a total dollar error.

4. Underpayment.--Enter the number four if the net amount of all dollar errors results in an underpayment.

SECTION IV - OPTIONAL USE CODES

This section is provided for optional State use.

SECTION V - RE-REVIEW FINDINGS

Do not complete this section. It is for Federal regional office re-review purposes only.

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THIS PAGE RESERVED FOR

CLAIMS PROCESSING ASSESSMENT SYSTEM REVIEW SCHEDULE

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11606. ALTERNATE SYSTEM

The purpose of the alternate system is to allow States not required to perform a mandatory system to determine the type of claims processing quality control system they feel will best serve their needs.

Alternate systems may take many forms. These systems may involve computerized reviews of the entire claims file, reviews which focus upon certain claims strata or aspects of the claims processing, and other subsystems, etc.

Alternate systems must be able to:

1. Identify deficiencies in the claims processing,

2. measure the cost of deficiencies,

3. provide data to determine appropriate corrective action,

4. provide an overall assessment of the State's claims or that of its

fiscal agent,

5. provide for a claim-by-claim review where justifiable by data, and

6. produce an audit trail that can be reviewed by HCFA or an outside auditor.

Each State which qualifies to operate an alternate system must submit a plan to the HCFA regional office detailing how their system will operate and what data is to be generated from their system. No specific format is required for the submission of this plan. States must receive prior approval before implementing an alternate system.

Reporting Requirements.--States operating alternate systems must provide an annual report of the results of their CP assessment to the HCFA-RO no later than August 31. Detail the methodology employed in determining errors and include descriptions of errors. Deficiencies discovered in the CP system and actions taken to correct deficiencies must also be detailed.

Deficiencies in claims processing operations are:

1. Payment for incorrect, inconsistent, or incomplete claims;

2. errors which result in incorrect, inconsistent or incomplete data entries;

3. payment to a provider not eligible to participate in the program;

4. payment for a service furnished to an ineligible individual;

5. payment for services not authorized by regulation or policy;

6. payment above allowable charges or costs;

7. payment for which an individual was responsible; and

8. duplicate payment.

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