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7275. INSTRUCTIONS FOR INTEGRATED REVIEW SCHEDULE (IRS) - Form HCFA 301

An IRS is required for each MEQC sampled case. (This includes each case in the AFDC stratum including drops.) The worksheets must contain documentation for the information entered on the IRS. Refer to The Integrated Manual for AFDC, Adult, Food Stamp, and Medicaid Eligibility Quality Control Reviews for detailed completion instructions.

Following the eligibility review, complete Form HCFA 301, except for the dollar amount, under Detailed Error Findings and the Payment Review Information-Medicaid.

Following the payment review, complete the dollar amount under Detailed Error Findings and the Payment Review Information-Medicaid sections.

Code technical errors (discussed in §7309) at the bottom of the Detailed Error Findings section. Do not code any dollars for these errors. Circle each detailed error and line through the dollar amount.

7278. ADMINISTRATIVE PERIOD

Quality control procedures provide for a reasonable period of time for States to reflect changes in the circumstances of the assistance group. MEQC refers to this period of time as the administrative period. For MEQC purposes, the administrative period is the review month and month prior to the review month. However, a State plan may impose a more restrictive period. The administrative period is designed to include all periods for advance notice, client reporting, agency investigation, and agency imposed time allowances for client action. Therefore, the administrative period provides for all such time allowances.

When an eligibility error is occasioned solely by the failure of case record data as of the review month to reflect changes in an assistance group's circumstances which occurred (a) during the review month (calendar or fiscal) or the month immediately preceding the review month, or (b) during the State's more restrictive administrative period, no case eligibility error exists (unless the medical assistance eligibility as of the review month was adjusted incorrectly). If the eligibility status of the assistance group was incorrect as of the review month and would still be incorrect disregarding the change in circumstances that occurred during the administrative period or applicable portion thereof, a case eligibility error exists. Use the case status for the review month in determining the type and amount of error if an error would exist even with application of the administrative period. The administrative period does not apply to State policy changes.

The change in circumstances is defined as the point at which a change causes the case to be in error (or to become correct). For example, if a beneficiary becomes employed in late February but earnings do not exceed the income limit until March, the change in circumstances for this case occurs in March. A change in circumstances must occur in the review month or month prior to be disregarded in the MEQC process.

In the concept of the administrative period, the date of action is the date on which the State Agency responds to a beneficiary's change in circumstances by revising his/her eligibility/liability status. In applications and redeterminations, the date the State Agency inputs the change into the eligibility system is considered to be the date of action.

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If the State agency takes an incorrect action during the administrative period, MEQC must report that error. For example, if a beneficiary reports an increase in income and the State agency incorrectly acts upon that change, that action is subject to MEQC error citation.

As it applies to initial eligibility determinations, the administrative period may be affected by the date the case is approved for Medicaid (approval date) and the date the State agency enters the case into the system (systems action date) for Medicaid eligibles. If a change in circumstances occurs prior to the application date, the administrative period to reflect that change does not apply. For example, assume an application date is January 15, the approval date is January 25, and the systems action date is February 1. If a change in circumstances occurs January 14, the administrative period does not apply. However, if the change occurred January 25 or later, it applies.

Apply the administrative period to each program area. A program area has been defined as a program element of eligibility, e.g., Bank Accounts or Cash on Hand (211), Other Liquid Assets and Personal Property (213), and Real Property (221).

If there are two errors within one program element and one occurred prior to the administrative period while the other occurred within the administrative period, both are countable. However, if they are not within the same program element, i.e., 211 and 221, but the dates of errors exist as above, only the earlier one is countable because the elements are not the same and the second occurred within the administrative period.

The administrative period includes all changes of circumstances which affect beneficiary eligibility/liability.

An exception to MEQC looking first at the review month in determining eligibility occurs in cases when the beneficiary died in the month prior to the review month. In such cases, determine eligibility as of the date of death. If the case was in error as of that point and throughout the prior part of the administrative period, the case is in error regardless of what occurred subsequent to the beneficiary's death.

Note that the administrative period does not apply to retrospective budgeting.

7300. CLASSIFICATION OF ERRORS

The MEQC process may result in the following types of errors.

A. Eligibility Errors.--An eligibility error exists when a beneficiary and/or case does not meet all elements of eligibility.

B. Not Eligible for Services Received Errors.--This is applicable in States which cover more services for the categorically needy than for the medically needy and in States which provide home or community-based waiver services.

C. Liability Error.--A liability error exists when an individual case has its spenddown, amount of cost sharing, or contribution toward the cost of long term care incorrectly determined.

Report the total amount of all errors. However, do not report understated liability errors which total less than $5 in both the eligibility review and the payment review. See 42 CFR 431.804 for specific information on how to determine the erroneous payment amount from various errors.

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D. MEQC Findings Which Are Not Eligibility Errors.--Examples of these findings are as follows:

o Ineligibility in periods other than the review month. An ineligible individual who dies in the month prior to the review month is considered ineligible in the review month;

o Incorrect agency administrative procedures which do not affect eligibility; and

o Technical errors.

While this information does not contribute to the MEQC findings regarding eligibility of cases during the review month, refer information to the appropriate administrative or program unit for further investigation.

7303. ELIGIBILITY ERRORS

An eligibility error during the review month exists when the case or a beneficiary in the case fails to qualify for any Medicaid eligibility coverage specified in the State plan as of the review month. For example, ineligibility exists when the case has no categorical relationship during the review month. An eligibility error also exists when a case does not meet a Medicaid coverage requirement during a specified period of the review month when, according to a State's eligibility plan, eligibility for a day does not mean eligibility for the entire month.

Evaluate changes in situations which have occurred since the last agency determination as they affect eligibility coverage requirements as of the review month. For example, an AFDC categorically related beneficiary may have been determined as eligible for Medicaid based in part on deprivation due to the father's absence from the home. The reviewer finds that the father returned to the home, but the deprivation element still exists due to the disability of the father as of the review month. Change in the deprivation element does not affect the basic eligibility of the beneficiary under the coverage requirement in question.

Actions taken subsequent to the review month and their effect on the beneficiary's eligibility and payment status fall outside the scope of MEQC. As such, they do not affect the MEQC review findings.

7306. REPORTING OF ELIGIBILITY ERRORS

An eligibility error must relate to an element(s) of eligibility on the worksheet which causes the case to be ineligible or have an incorrect liability amount. When coding errors on the IRS, record each individual error in the Detailed Error Findings section. If there is more than one error in an element, code each one.

This also applies to beneficiaries who are dually eligible QMB/non-QMB individuals when the MEQC eligibility findings are different for the coverage categories. (See §7343 for QMB error coding.)

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The error category known as "eligible with ineligible services" is applicable in States which provide more services for the categorically needy than for the medically needy, in States which have home or community-based waiver provisions, and States which supply emergency services to illegal aliens.

Report eligibility review findings to the State or local unit, as appropriate, using the State's established process. These units are expected to follow up on MEQC review information and take action which is consistent with the State plan.

7309. TECHNICAL ERRORS

Regulations implementing the MEQC provisions of §1903(u) of the Act define technical errors as those "errors in eligibility conditions which, if corrected, would not result in a difference in the amount of medical assistance paid." These paperwork eligibility errors are to be excluded from the computation of the MEQC payment error rate. Do not code dollar error amounts on the IRS for technical errors.

Technical errors for MEQC purposes include the following:

o Work incentive program requirements,

o Assignment of social security numbers (enumeration requirements),

o Requirements for a separate Medicaid application,

o Monthly reporting requirements,

o Assignment of rights to third party benefits as a condition of eligibility for Medicaid,

o Failure to apply for benefits for which the family or individual is eligible,

o Failure to locate a case record when available evidence shows that an application was filed,

o Failure to record proper verification of pregnancy if later documentation established pregnancy in the review month,

o Failure to submit required reports for work transition Medicaid coverage, and

o Failure to obtain a written declaration by a beneficiary stating whether (s)he is a citizen or national of the United States.

Additional potential technical error situations may arise. Refer them to supervisory personnel for contact with the RO for instructions. The RO then contacts CO for a determination. Only those additional technical errors approved by HCFA can be excluded in determining error rates.

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While technical errors are not included in the error rate, they are to be identified in completing the MEQC review and coded on the IRS. Code them after all other errors and place them at the bottom of the Detailed Error Findings. Circle the line(s) on which these errors are coded and line through the dollar amount. Do not code dollar amounts for technical errors.

7310. HIERARCHY OF MEQC ERRORS

In completing the Detailed Error Findings section of the IRS for non-QMB or QMB only, cite errors in the following order to properly associate erroneous payments with eligibility and liability errors:

o Eligibility errors other than for excess resources and technical errors,

o Eligibility errors because of excess resources,

o Liability errors,

o Eligible with ineligible service errors, and

o Technical errors (erroneous payments not applicable).

Ineligible service errors for dually eligible QMB/non-QMB individuals are eligibility errors and, therefore, are included in the first category of the hierarchy of errors.

In the above hierarchy, associate dollars with the errors in the order given. Thus, in any case with an eligibility error (other than for excess resources and technical errors), associate all dollars with that error and no dollars with any remaining errors. In a case with an eligibility error because of excess resources (but no other eligibility errors), code the lesser of the amount of paid claims or excess resources as the dollar error. If this same case also had a liability error, assign that error any dollars not already assigned to the excess resource eligibility error (a case with an eligibility error other than for excess resources or technical errors already has had all dollars coded to that error and therefore has no dollars remaining with which to associate the liability error). If a case has no eligibility errors but does have a liability error, assign dollar values to the error(s) per current procedures as indicated in §7318. As previously stated, do not associate dollars with technical errors.

7312. ELIGIBLE WITH INELIGIBLE SERVICES

The explanation below is applicable for cases that are not dually eligible as QMB/non-QMB or SLMB/non-SLMB.

The regulation implementing §1903(u) of the Act established an error category known as eligible with ineligible services. This type of error occurs in States which provide more services for the categorically needy than for the medically needy. In such States, a medically needy case which the State agency had incorrectly certified as categorically needy may receive services which would not have been provided had the case been correctly certified as medically needy. This case is eligible for Medicaid but not for the particular categorically needy service received.

Affected States must review all claims for services received in the review month for every type of case in the sample identified below to determine if any ineligible services were received by any case member(s).

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Note that we are speaking of ineligible services received solely due to an incorrect eligibility determination, i.e., categorically needy only services received by an individual/case which is really medically needy but was incor- rectly certified by the State Agency as categorically needy. If the case is correctly coded in the system as medically needy but a categorically needy only service is paid by Medicaid, it is a claims processing error and is not coded as an eligibility error.

A. Types of Cases Which Require Review.--The following cases require review.

o Cases found eligible by MEQC as medically needy which were certified by the State agency as categorically needy,

o Medically needy cases with liability understated or overstated errors which were certified by the State agency as categorically needy,

o Medically needy cases with excess resources less than the total amount of review month claims which were certified by the State agency as categorically needy,

o Categorically needy individuals receiving services for which they are not eligible, i.e., home and community-based waiver beneficiaries who received services not allowed by the waiver, and

o Illegal aliens eligible to receive only emergency services.

If a State's policy is to pay for a beneficiary's Medicare Part B premium, then Part B coverage is assumed to be available to the beneficiary. Thus, if a beneficiary fails or refuses to enroll in Part B under these circumstances, he/she is ineligible for services that otherwise would have been covered under Part B.

These errors can only be found during the payment review. They cannot be found in the initial eligibility review. Four possible findings result from receipt of a service for which the case or case member was not eligible: eligible with ineligible services, liability overstated with ineligible services, liability understated with ineligible services, or ineligible.

For cases or individuals found eligible with ineligible services, code the case as such on the IRS. The dollar error is the amount of payments for which the case or individual(s) was ineligible, i.e., the total amount of claims paid for noncovered services or, for cases found ineligible for the categorically needy program due to excess resources, the lesser of the amount of noncovered services or the amount of resources in excess of the categorically needy level.

If the case finding is liability understated with ineligible services, code the case liability understated with ineligible members on the IRS. The element and nature codes are 550 and 113 respectively. The liability error takes precedence over the ineligible service error(s) in determining the amount of misspent dollars to apply to each error. Thus, code the liability error first.

B. Rules For Determining Amounts Cited For Different Errors.--

1. Determine the chronological sequence of services received to be applied to the review month.

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2. Apply the liability error to the first claims of the month, in order of date of service, assuming that if the beneficiary had not erroneously received a Medicaid card he/she would have met his spenddown chronologically. This applies whether the claim is for a covered service as long as it meets the definition of an expense which can be used to meet spenddown. The full amount of the unmet liability as of the review month is the misspent total for that error in every instance.

3. Only those claims not used to meet the spenddown as described above can be cited for the ineligible service error(s).

EXAMPLE (One-month spenddown):

Date of service 10/1 10/4 10/10 10/21

Amount of correct claims

paid for services

received on those dates $21 $12 $53 -

Ineligible services received - $17 - $37

There is $36 in unmet liability in this case as of the review month. Twenty one dollars would have been met on October 1 if the beneficiary had not erroneously received a Medicaid card, leaving an unmet liability of $36 less $21, or $15. On October 4, the beneficiary received two services, one for which he/she is eligible and one for which he/she is not. The spenddown is applied first to the service for which he/she is not eligible. All of the $15 liability is met with $2 of the ineligible services remaining.

Thirty six dollars are considered misspent due to the liability error (this error is coded first on the IRS) and $39 due to the ineligible services ($2 from October 4 plus the $37 claim for the ineligible service received October 21). The total erroneous payment in this case is $36 plus $39, or $75.

If the case finding is liability overstated with ineligible services, code the case liability overstated with ineligible members on the IRS. The element and nature codes are 550 and 113 respectively. The dollar error for the ineligible services is the full total of ineligible services for the month.

A fourth finding of ineligible is possible for cases with excess resources, the amount of which is less that the full amount of paid claims for the review month, who have also received services for which they are ineligible.

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Code this type of case ineligible on the IRS. Again, the element and nature codes for the ineligible service error(s) are 550 and 113 respectively. The full amount of the excess resource (the amount by which the resources exceed the standard) is coded as the dollars in error for that element. The ineligible services error are coded next. The amount of that error cannot exceed the difference between the excess resource error and the amount of paid claims for review month services.

Use the logic applied in computing payment errors for liability understated cases with ineligible services cited above in computing final liability error amounts for cases where paid and denied claims or billed amounts from prior months in the spenddown period are used to offset liability.

7315. ERRONEOUS PAYMENT COMPUTATION

When dollar errors are cited in more than one element during a case review, the total dollar error cannot exceed the amount of paid claims. This includes all eligibility, understated liability, and ineligible service errors. When computing the final dollar amounts of these errors, keep in mind the error hierarchy as discussed in §7309.

For erroneous payment computation purposes resulting from ineligibility or understated liability, the amount of error is the lesser of:

o The amount of payments made on behalf of the family or individual for the review month, or

o The difference between the correct amount of beneficiary liability and the amount of beneficiary liability met by the individual or family for the review month.

Code these errors as discussed in §7318.

For erroneous payments resulting from excess resources the amount of error is the lesser of:

o The amount of claims payments made on behalf of the family or individual for the review month, or

o The difference between the actual amount of countable resources of the family or individual for the review month and the State's applicable resource standard in the approved State plan.

For erroneous payments due to an eligibility error resulting from other than excess resources or failure to properly meet beneficiary liability, the amount of error is the total amount of medical assistance payments made for the individual or family under review for the review month. Cite these erroneous payments as eligibility errors. In completing the IRS for excess resource cases, cite the lesser amount of excess resources or paid claims.

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7316. DOLLAR AMOUNT OF CASE ELIGIBILITY ERRORS

The only amount of dollar error computed during the eligibility review phase is the dollar amount of overstated or understated liability and for cases ineligible due to resources the dollar amount by which resource(s) exceeds the State's allowable limit. The following chart shows the eligibility error and the dollar amount of the error to be cited on the eligibility review.

For coding of errors on cases involving those who are dually eligible as QMB/non-QMB individuals, see §7343. The explanation below is applicable to cases other than those involving beneficiaries who are dually eligible QMB/non-QMB individuals.

Type of Error Dollar Amount of Case Error for Eligibility Review

Case is ineligible Zero dollar amount.

during part or all

of the review month

due to elements

other than the

resource elements

(200).

Case is ineligible The dollar amount by which the resource(s)

during part or all exceeds the State's allowable limit.

of the review month (Code in section V, item 65 of the IRS.)

due to excess

resources (elements

200).

Case eligible during Zero dollar amount.

review month with

ineligible case mem-

bers due to elements

other than the

resource elements.

Case eligible during The dollar amount by which the resource(s)

review month with exceeds the State's allowable limit.

ineligible case mem-

bers due to excess

resources

(elements 200).

Case liability The full understated case liability amount.

understated. (Item 64 of the IRS.)

Case liability The full overstated case liability amount.

overstated. (Item 64 of the IRS.)

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When the type of error is eligible with ineligible services by itself or in combination with any of the above, do not note any additional dollar amount of error for the eligibility review. Assign ineligible service dollar amounts at the time of payment review.

Note that the final amount of misspent Medicaid funds cannot be determined during the eligibility review. Associating misspent dollar amounts with these eligibility errors must await identification of paid claims for services rendered which are credited to the review month (payment review).

For reviews which have multiple liability errors, the overall liability error amount is the net effect of all errors.

7318. COMPUTATION OF LIABILITY ERRORS

Use this section for cases involving Medicaid coverage categories other than QMB. For cases involving beneficiaries who are dually eligible as QMB/Medicaid individuals, refer to §7343 for explanation as to how to use this section.

For cases with excess income (subject to spenddown), code an error finding liability understated, not ineligible. This finding is subject to change during the payment review.

In any case found to have excess income, thoroughly examine the case record to see if it contains evidence of incurred medical expenses not used by the agency in computing beneficiary liability. Explore with the beneficiary during the home visit any additional documented incurred expenses which can be used to offset excess income. Determine if any of the incurred medical expenses used by the agency and additional incurred expenses not used by the agency were subject to payment by a third party. Medical expenses subject to payment by a third party cannot be used to offset excess income.

1. Case Failed to Meet Liability as Computed.--If a beneficiary fails to meet liability as computed prior to certification, do not consider the case ineligible during the eligibility review. Undertake a complete review of case circumstances. If the beneficiary has an unmet liability in the review month, code the error as liability understated in the full amount of the understatement.

2. Case on Eligibility File Subsequent to Expiration of Certification Period.--If a case remains on the eligibility file and is selected for review in a month subsequent to expiration of the beneficiary's certification period, examine it to determine eligibility. Assume that a new spenddown period would have begun at the end of the prior certification period unless the end of the prior certification period preceded the review month by more than the State's prescribed spenddown period. If so, the review month then becomes the first month of a hypothetical spenddown period. If excess income is found, code the error as liability understated.

3. Ineligible AFDC Cash Assistance Case.--Cases or individuals found ineligible for cash assistance by AFDC-QC due to excess income may be eligible for medical assistance with a spenddown if coverage code 43, extended benefits,

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7318 (Cont.) REVIEW PROCESS 09-92

is not applicable. In those States which allow spenddown by AFDC-related MEQC cases, treat an AFDC case with income in excess of the medically needy income level (MNIL) as any other case with unmet liability. Construct a spenddown period using the review month as the first month of the period. Calculate the amount of excess income and code the error as liability understated. Note, however, that an AFDC case found to have income in excess of the AFDC cash assistance standard but less than the State MNIL is eligible for medical assistance under coverage code 69 with no liability to be met.

4. MAO Case Receiving Benefits Under Extended Coverage Provision.--For MAO cases receiving benefits under the extended coverage provision (code 43) and for which the review month is any month subsequent to the final month of continued eligibility, construct a spenddown period beginning with the next month if the case has excess income. If, however, that month precedes the review month by more than the State's prescribed spenddown period, the review month becomes month one of the spenddown period. The case must be reviewed for eligibility under a coverage code other than 43 because extended benefits no longer apply.

5. MAO Case Found Eligible Only With Spenddown.--For MAO cases found eligible by quality control only with spenddown but found eligible by the State agency with no spenddown, use the spenddown period used by the State agency to compute liability (even if no liability amount was found). If the State agency did not use a spenddown period to compute liability, begin the period with the month of the last redetermination/application preceding the review month unless the date of the action preceded the review month by more than the State's prescribed spenddown period. In this event, the review month becomes month one of the spenddown period.

EXAMPLE: If, in a 6-month spenddown State, the last redetermination was no more than 5 months prior to the review month, the month of last redetermination is the first month of the spenddown period constructed by quality control. If the month of the last redetermination had preceded the review month by 7 months the review month becomes month one of a hypothetical spenddown period. Assume, for example, that the review month is June and the latest redetermination was in January. January is the first month of the spenddown period constructed by MEQC. However, if the review month was June and the latest redetermination was made in the previous September, then June becomes month one of the hypothetical spenddown period.

6. States Which Begin a New Spenddown Period When an Income Change Causes a Change in Beneficiary Liability.--If a State automatically begins a new spenddown period when an income change causes a change in liability, begin the spenddown period with the month of the last redetermination/application if the income change occurred prior to that date. If the date of that action preceded the review month by more than the State's prescribed spenddown period, the review month then becomes month one of the quality control spenddown period. If the income change occurred subsequent to the last redetermina­tion/application date, the month of the change becomes the first month of the spenddown period unless it too precedes the review month by more than the State's prescribed spenddown period. In this case, the review month becomes month one of the spenddown period.

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7. Liability Understated With Ineligible Services.--See §7312.

7319. REVIEW MONTH INCOME PROJECTED FORWARD THROUGHOUT SPENDDOWN PERIOD

MEQC looks at all months of the spenddown period up to and including the review month. If the MEQC review month liability is different from the agency projection, recompute the liability for the entire spenddown period projecting the review month income forward. (For those States which utilize a spenddown period of more than one month, liability computation for the review month is NOT reviewed in isolation.) Although MEQC may know the actual income available for the entire spenddown period, focus the review on the circumstances as of the review month, since this is, at most, the information that would have been available to the agency. Therefore, project only the review month income throughout the remaining spenddown period.

7321. IDENTIFICATION OF CLAIMS FOR SERVICES

Following the eligibility review for all completed cases, all claims paid for services received in or applied to the review month for all case members must be identified. A claim is defined as a specific line item on a provider voucher for which there is a fee charged. For crossover claims and inpatient hospital claims, a number of different services may be included. These are normally treated as single line items. Occasionally, the only information available is from tape to tape billing or from other electronic media. When these billings contain Part B services, it may be necessary to access intermediary records to determine which services were received in the review month. Identification may be by use of beneficiary profiles, claims histories, or invoices. Use these or other sources which best provide the information needed. Crossover claims are to be treated as other claims for purposes of claims collection. When adjustments have been made, use the adjustment in computing the total dollar amount of claims. Do not verify the correctness of the adjustment. Adjustments to claims may only be considered during the administrative period, which for paid claims is the month the claim was paid and the following month. See §7126 for additional information on claims collection. HMO premiums and Medicare buy-ins are considered claims for the month of medical care which they cover.

7324. ROUNDING TO NEAREST DOLLAR

When determining the total dollar amount of claims, add the amount of all claims and do not round until a final sum is reached. Then round to the nearest dollar. If the final cents amount is $.50, round up to the next dollar. This is MEQC policy for all situations in the manual which require rounding.

7327. DETERMINING FINAL MISSPENT DOLLAR AMOUNTS OF CASES CONTAINING INITIAL ELIGIBILITY ERRORS

Use this section for cases involving Medicaid coverage categories other than dually eligible QMBs. For cases involving QMB/Medicaid beneficiaries, see §7343.

The worksheets provide documentation of the eligibility errors. The paid claims or profiles allow the reviewer to associate dollar amounts with eligibility errors. Sections 7303ff present the procedures to determine if a case is in error. In the following sections, the procedures for associating misspent dollar values with eligibility errors are described.

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7327 (Cont.) REVIEW PROCESS 11-93

At this stage in the MEQC review, determine the following from the eligibility QC worksheets:

o The eligibility status of each beneficiary in a case; and

o The element(s) of eligibility that was found to be in error and the nature of the errors.

These constitute the primary information needed for computing and reporting the dollar value of eligibility errors. In addition, have available the dollar amount of paid claims for each beneficiary for services received during the review month. A major purpose of the MEQC system is to measure misspent Medicaid funds.

Therefore, if a case is found to be ineligible during the review month but had no paid claims for services received during that month, no Medicaid funds have been inappropriately expended, i.e., if there are no review month claims for a case, the value of an eligibility error is 0 (zero).

A. Computing Dollar Amount of Eligibility Errors.--For each beneficiary who has been found to be ineligible during the initial eligibility review, determine the primary error leading to the error finding. Enter the appropriate dollar amounts for the identified primary error in section VI of the IRS. For cases with excess resources, the amount of the error is the lesser of the review month claims or the amount of excess resources. When citing multiple errors, follow a hierarchy of error citation when completing the IRS. This is to properly associate misspent Medicaid funds with eligibility and liability errors. Assign dollar amounts to errors by element. If more than one element contributes to the total dollar error, specify how dollars are to be assigned to each element.

B. Order for Citing Errors.--Cite errors in the following order:

1. Eligibility errors other than for excess resources and technical errors,

2. Eligibility errors for excess resources,

3. Liability errors,

4. Eligible with ineligible services, and

5. Technical errors.

7330. DETERMINING FINAL MISSPENT DOLLAR AMOUNTS OF CASES CONTAINING INITIAL LIABILITY UNDERSTATED ERRORS

An initial finding of liability understated during the eligibility review is subject to modification during the payment review. In order to compare the actual eligibility

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12-85 REVIEW PROCESS 7330 (Cont.)

determined by the agency, the definition of incurred medical expenses (for MEQC purposes only) must include Medicaid paid claims (or billed amounts, if appropriate) for services received by case members during all months of the spenddown period including the review month. (NOTE: These instructions apply to all cases with an initial liability understated error. See §7318 for a definition of cases included in this error code. The procedures for determining the final misspent dollars for institutional cases are described in §7333.)

The beneficiary profiles will normally be requested at the beginning of the sixth month following the review month but may be requested as early as the fifth month. They will include claims for services rendered at any time in the spenddown period through the review month which are paid by the end of the fourth month after the review month. States which have permission to pull claims monthly may continue to do so.

If the agency had correctly computed liability and had not prematurely issued a Medicaid card to the case member(s), allowable medical expenses incurred by the recipient (as well as any expenses erroneously paid by Medicaid) would have been the case member's obligation and could have been used to meet liability. Therefore, these expenses must be used in the payment review to offset the initial beneficiary liability.

States may also search for and use in the payment review calculation any claims rejected for payment by Medicaid because they were for a noncovered service or were rendered by an uncertified provider but which would meet the definition of an allowable expense to meet a spenddown. These denied claims are to be chronologically applied along with paid claims when used to offset liability. Claims rejected for technical reasons are generally resubmitted for payment; e.g., provider ID number missing. Therefore these claims usually do not become the beneficiary's obligation and are not used to offset liability as an incurred expense.

States may also opt to use the total amount billed by the provider to offset the initial understated liability rather than the amount paid by Medicaid. If a recipient were incurring his/her own expenses the full amount incurred would have been allowed to meet liability. By applying this principle to the payment review calculations the billed amount would be used to offset beneficiary liability.

Paid claims (or billed amounts if the State so opts) prior to the review month can also be used to offset excess income. This can be done from the point at which the income causing the error became available to the case member(s) or from the first month of the spenddown period affecting the review month, whichever comes later.

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7330 (Cont.) REVIEW PROCESS 12-85

When using billed amounts to offset liability first apply billed amounts for months up to the review month to determine the review month liability. Once the review month liability is determined utilize billed amounts to offset liability in the order incurred. This is important since only the dollars paid for the bills used to offset liability will be coded as misspent funds. (See Examples 14 and 15 for details.)

Note that misspent funds can never be greater than the review month paid claims regardless of the billed amount; e.g., a case with a $100 liability error, $150 in billed amounts for the review month, but only $20 in review month paid claims cannot have more than a $20 error.

States must notify the HCFA Regional Administrator (RA) of their choices on the options to use denied claims and/or billed amounts prior to commencing application of this policy. Once the choices have been submitted in writing and approved the State is required to conduct all reviews in the chosen manner. The choices are binding for at least one full sample period but may be revised at the end of each period. Submit any changes as a part of a State's sampling plan.

To determine the actual case status as of the review month and to compute misspent dollars obtain the following:

1. Eligibility findings and completed worksheets for all cases containing liability understated errors,

2. Any claims rejected for payment because they were for a noncovered service or because they were rendered by an uncertified provider but meet the State definition of an allowable expense to meet spenddown if a State elects this option,

3. Beneficiary profile relating to paid review month claims for all cases with understated liability, and

4. Beneficiary profiles of Medicaid paid claims (or actual claims in States which cannot produce beneficiary profiles) for services received by each case member during all other months of the spenddown period. If the liability error was caused by an income increase which occurred in a month other than the first month of the spenddown period obtain beneficiary profiles or claims for all services provided from the month of the increase through the review month. In States with a one-month spenddown period only review month claims must be obtained.

Paid claims (or billed amounts) as well as denied claims which meet the criteria above are used to offset the initial understated liability from the first month of the spenddown period or from the point within the period when increased income caused the computation

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to be in error, whichever is later. Claims used during the payment review to offset the initial liability understated amount must be carefully cross-matched with medical expenses used by the agency or with any additional incurred medical expenses utilized during the eligibility review to reduce liability. Any paid claim which was found during the eligibility determination or eligibility review to be an incurred medical expense and used to offset beneficiary liability may not be considered again during the payment review to further reduce the liability understated error. In addition, do not use any review month claim(s) or portion of a claim found during the payment review to be the responsibility of a third party to reduce beneficiary liability.

Based on the preceding application of claims, one of the following will result.

1. If the sum of the Medicaid paid claims (or at State option billed amounts) for services received prior to the review month and (at State option) certain denied claims for services received prior to or during the review month is equal to or exceeds the initial liability understated amount the final case finding will change to eligible.

2. If liability is met during the review month the final case finding remains liability understated. (NOTE: The one exception to this involves the use of denied claims as described above.)

3. If liability is not met during the review month the final case finding will change to ineligible.

In certain cases an original finding of eligible is subject to change during the payment review to liability overstated/understated or ineligible. This occurs when liability is correctly computed by the agency but MEQC establishes during the payment review that a third party paid totally or in part for a service incurred by the recipient and used to offset initial beneficiary liability; e.g., that portion of a hospital bill used to offset liability is paid by a third party.

Retain copies of beneficiary profiles and/or claims collected for the spenddown period and used in the payment review computation in the MEQC file. Show the computation which determines the correct case eligibility status as of the review month and the amount of misspent funds, if any, in the MEQC file.

Examples 1-12 utilize paid claims to offset beneficiary liability rather than billed amounts. Examples 13 and 14 utilize billed amounts to offset beneficiary liability. The examples utilize only 6-month and one-month spenddown periods since the payment review process used in a 6-month spenddown State is identical to that which would be used in States having 2, 3, 4, or 5-month periods. Details on coding the review schedule are explained in the Integrated Review Manual.

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EXAMPLE 1 - ORIGINAL FINDING OF LIABILITY UNDERSTATED CHANGES TO INELIGIBLE.

The agency computed a $100 spenddown for a beneficiary on January 1 which he immediately met and was thus certified eligible for medical assistance from January 1 through June 30 (6-month spenddown State). MEQC reviews the case for January and finds the beneficiary had more income in January which is expected to continue in subsequent months than the agency had used in its calculation and that the beneficiary had no additional expenses to offset the excess income. MEQC computes a spenddown of $300 and finds an initial liability understated error of $200.

$300 Correct Spenddown

- 100 Already Met

$200 Liability Understated Error

Claims collected for January are as follows:

Medicaid Claims $50

If the beneficiary had not erroneously received a Medicaid card in January he would have been responsible for the $50 worth of services received in January leaving $150 of unmet liability. Thus, even had he not received a card in January, he would not have met his liability in that month. He is ineligible, and the full amount of Medicaid paid claims ($50) is misspent funds. The original finding of liability understated will be changed to ineligible in the payment review, and will show $50 of misspent eligibility funds.

EXAMPLE 2 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $200 DECREASES TO LIABILITY UNDERSTATED $150.

Claims collected for January and February are as follows:

January February

Medicaid Claims $50 $200

Had this same case been selected in February the final dollar error would have been $150 liability understated. Had the beneficiary not erroneously received a Medicaid card, February would be the month in which he would have met his liability and $150 would be the amount he would have incurred in that month; i.e., only $50 of the $200 claim would have been correctly paid by Medicaid. In this situation the error will always equal the amount of unmet liability in the review month.

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EXAMPLE 3 - ORIGINAL FINDING OF LIABILITY UNDERSTATED CHANGES TO ELIGIBLE.

Claims collected for January, February, and March services are as follows:

January February March

Medicaid Claims $50 $200 $125

Had this same case been selected in March there would be no misspent funds. If the beneficiary had not erroneously received a Medicaid card in January $50 of the liability would have been met in January leaving $150 of unmet liability. This liability would have been met in February if the beneficiary had been held responsible for the first $150 of the $200 paid by Medicaid. Thus, $50 was correctly paid in February, but $150 was erroneously expended. By March the client would have legitimately been eligible for Medicaid had the agency correctly computed his liability. There are no misspent funds in March. Change the original liability understated error in the payment review to eligible.

Note that a case has an equal chance of being selected in any month of a spenddown period. As shown in the previous examples, the error finding will vary depending upon which month of the spenddown period is the review month.

EXAMPLE 4 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $150; DECREASES TO LIABILITY UNDERSTATED $70; ONE INCOME CHANGE IN SPENDDOWN PERIOD.

In the preceding examples the excess income became available to the beneficiary at some point prior to January; thus Medicaid paid claims could be used to offset excess income beginning with January, the first month of the spenddown period. Examples 4 and 5 reflect income which becomes available to the recipient after the beginning of the spenddown period. (NOTE: These examples are not applicable to States which automatically begin a new spenddown period when income changes.)

Jan. Feb. Mar. Apr. May June

(Review Month)

Medicaid Claims $ $ $ $ 65 $ 15 $ 100

Actual Income

found by MEQC 200 200 200 250 250 250

Income Used by

Agency to

Compute Liability 200 200 200 200 200 200

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Agency Computation MEQC Computation

$ 200 Monthly $ 200 Income $ 250 Income

x 6 Months x 3 Months (Jan.-Mar.) x 3 Months (Apr.-June)

$ 1,200 Total Income $ 600 $ 750

- 1,000 Income Level

$ 200 Excess Income

(Case record contains $ 600

documentation of cor- + 750

rectly met spenddown $ 1,350 Total Income

prior to certification - 1,000 Income Level

in mid-January) $ 350 Excess Income

- 200 Previously Met

$ 150

- 0 Additional Incurred Expenses

$ 150 Unmet Liability

During the initial eligibility review this case would have been coded with a $150 liability understated error. In the payment review, claims/beneficiary profiles need only be obtained for the months of April, May, and June because the income increase causing an error in the spenddown computation did not occur until April. Had the beneficiary reported his increase in a timely fashion it is only in April that the agency would have suspended benefits and instructed the beneficiary to incur an additional $150 in medical expenses. Therefore, beginning in April the client is responsible for claims paid by Medicaid and will use those claims to offset unmet liability. In the example there is an unmet liability of $150; $65 is met in April, a total of $80 ($65 in April plus $15 in May) is met by the end of May, and the additional $70 is met in the review month. However, since Medicaid did pay $70 erroneously in June, the payment review finding shows a true eligibility dollar error (liability understated) of $70.

EXAMPLE 5 - ORIGINAL FINDING OF LIABILITY UNDERSTATED CHANGES TO ELIGIBLE; TWO INCOME CHANGES IN SPENDDOWN PERIOD.

Jan. Feb. Mar. Apr. May June

(Review Month)

Medicaid Claims $ 40 $ 200 $ 65 $ 100 $ 60 $ 25

Actual MEQC

Income 210 210 210 250 250 250

Agency Income

Figures 200 200 200 200 200 200

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Agency Computation

$ 180 Private Pension

+ 20 VA

$ 200 Monthly Income

x 6 Months

$ 1,200 Total Income

- 1,000 Income Level

$ 200 Excess Income

$200 in medical expenses incurred prior to certification - verified in case record.

In order to correctly determine review month eligibility it is important to know that the VA error occurred prior to January and that the pension error first occurred in April.

MEQC Computation

First 3 Months Last 3 Months

$ 180 Pension $ 220 Pension

+ 30 VA + 30 VA

$ 210 Income $ 250 Income

x 3 Months x 3 Months

$ 630 $ 750

+ 750

$ 1,380 Total Income

- 1,000

$ 380 Excess Income

- 200 Previously Met

$ 180

- 0 Additional Incurred Expenses

$ 180 Liability

The initial eligibility finding would be a liability understated error of $180. Code both a private pension source error (element 346) and a VA source error (element 332).

The impact of the VA error alone on liability is computed in the payment review to determine the amount of unmet liability from January 1 through the end of March.

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It is only that amount that the beneficiary would have been expected to meet prior to the pension increase in April. Thus collect claims for January through June which would result in the following computations:

VA Error Alone

$ 180 Pension

+ 30 VA

$ 210

X 6

$ 1,260

- 1,000 Income Level

$ 260 Excess Income

- 200 Previously Met

$ 60 Unmet From January 1

Thus $40 paid for January services should have been the beneficiary's obligation leaving $20 which would have been met in February. In March there would be no misspent funds. Beginning in April the beneficiary would have been required to meet the additional $120 ($220 - 180 = $40; $40 x 3 months = $120) in liability caused by the pension increase. Of that, $100 would have been incurred in April and the remaining $20 met in May. By the review month of June the beneficiary is eligible; there is no error. Change the original State finding of liability understated to eligible in the payment review, and show no misspent funds in the payment review.

EXAMPLE 6 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $50 INCREASES TO $115, CASE CHANGES TO INELIGIBLE: MEDICAL EXPENSES USED TO OFFSET ORIGINAL LIABILITY AMOUNT WERE PAID BY MEDICAID.

MEQC reviews a case for June and finds excess income of $115 for the spenddown period of January 1 through June 30 due to undercounted income in January and subsequent months. During the field investigation, however, the recipient produces three incurred medical bills of $15 (March service), $15 (May service) and $35 (June service) which were not available to be used by the agency at the time of application to offset excess income. Thus, MEQC must reduce the $115 liability understated error by $65 and the error amount in the eligibility review becomes $50 liability understated. When spenddown period paid claims are collected during the payment review all three of the medical expenses thought to have been incurred by the recipient are found to have been paid by Medicaid.

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Jan. Feb. Mar. Apr. May June

(Review Month)

Total Medicaid

Paid Claims $ 0 $ 0 $ 15 $ 0 $ 40 $ 50

Amount Previously

Used to Offset

Liability 0 0 15 0 15 35

In this case the March claim of $15, the May claim of $15, and the June claim of $35 previously used by MEQC to offset the initial liability understated amount, must be added to the initial liability amount of $50 to establish the actual liability understated amount for the spenddown period. The payment review computation is as follows:

$ 50 Liability Understated Amount

+ 65 Claims of $15, $15, and $25 Previously Counted

$ 115 Revised Liability Understated

- 15 March Paid Claims

$ 100

- 40 May Paid Claims

$ 60

- 50 June (Review Month) Paid Claims

$ 10 Liability (unmet) in Review Month

The case is ineligible, and the full amount of actual Medicaid paid claims in June ($50) is misspent funds. Change the original State finding of liability understated to ineligible, and change the payment review to show $50 in misspent funds.

Had the paid claims for the spenddown period not been matched with incurred medical expenses used to offset beneficiary liability, and had the overlap not been discovered, May is the month in which the $50 liability would appear to have been met. In the review month of June the case would have been erroneously found eligible with no misspent funds.

EXAMPLE 7 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $50 INCREASES TO LIABILITY UNDERSTATED $60; MEDICAL EXPENSES USED TO OFFSET ORIGINAL LIABILITY AMOUNT WERE PAID BY MEDICAID.

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Jan. Feb. Mar. Apr. May June

(Review Month)

Total Medicaid

Paid Claims $ 0 $ 0 $ 15 $ 0 $ 40 $ 70

Amount Previously

Used to Offset

Liability 0 0 15 0 15 35

Assuming the case situation as shown in example 6, MEQC found an initial liability understated amount of $50. Claims for March, May, and June totaling $65, must be added back in to the initial liability amount since they were previously used by MEQC to reduce beneficiary liability. The payment review computation is as follows:

$ 50 Liability Understated Amount

+ 65 Claims of $15, $15, and $35 Previously Counted

$ 115 Revised Liability Understated

- 15 March Paid Claims

$ 100

- 40 May Paid Claims

$ 60

- 70 June (Review Month) Paid Claims

$ - 10 Liability Met in Review Month

If the beneficiary had not erroneously received a Medicaid card, June is the month in which he would have met his liability, and $60 is the amount he would have incurred himself. Only $10 of the $70 in claims would have been correctly paid by Medicaid. Therefore the case finding remains liability understated, and $60 is the unduplicated amount of misspent funds.

The situation is one in which the final dollar amount of misspent funds may exceed the liability understated amount coded during the eligibility review (when this understated amount is less then the amount of review month claims.) The original liability understated amount is increased during the payment review by adding back in those medical expenses thought to have been incurred by the recipient but actually found to have been paid by Medicaid. Note that although the amount of misspent funds for the review month may exceed the original liability amount they may never exceed the revised liability understated amount in the payment review (the sum of the original amount plus any paid claims which were also used to offset beneficiary liability).

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EXAMPLE 8 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $115 CHANGES TO ELIGIBLE; DENIED CLAIMS USED TO OFFSET EXCESS INCOME.

During the eligibility review the beneficiary may be unaware that he has incurred medical expenses. This situation can occur when Medicaid denies payment of a claim because it was for a noncovered service or was rendered by an uncertified provider; and it then becomes the beneficiary's obligation. If such denied claims are located by a State which has chosen the option of including denied claims during the payment review, and they meet the definition of an allowable expense to meet a spenddown, they should be considered in the payment review computation.

MEQC reviews a case for June and finds a liability understated error of $115 for the spenddown period of January 1 through June 30 due to undercounted income in January and subsequent months. When claims are collected during the payment review, three denied claims of $15, $20, and $10 for noncovered services are found. These claims are for services which meet the State's definition of allowable medical expenses for spenddown purposes and must be used in addition to the paid claims to reduce the initial liability understated amount.

Jan. Feb. Mar. Apr. May June

(Review Month)

Medicaid

Paid Claims $ 0 $ 0 $ 50 $ 0 $ 20 $ 35

Allowable

Denied Claims 0 15 0 20 10 0

In the example above the denied claims for February, April, and May must be used to reduce the initial liability amount in conjunction with the paid claims for March and May. The payment review computation is as follows:

$ 115 Liability Understated Amount

- 115 Denied Claims of $15, $20, and $10 plus March

paid claims of $50 plus May paid claims of $20

$ 0 Liability Met Prior to Review Month

The case is eligible in the review month of June and there are no misspent funds. Change the original State finding of liability understated to eligible, and show no misspent funds in the payment review.

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Had the denied claims not been considered during the payment review computation only the $105 in paid claims would have been deducted from the unmet liability as of the review month. The case finding would have erroneously been ineligible, and there would have been $35 (paid review month claims) in misspent funds for the case.

EXAMPLE 9 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $115 DECREASES TO LIABILITY UNDERSTATED $70; DENIED CLAIMS USED TO OFFSET EXCESS INCOME

In a one-month spend down State MEQC reviews a case for June and finds a liability understated error of $115 due to undercounted income. When claims are collected during the payment review two denied claims of $25 and $20 for services rendered by an uncertified provider are found. These claims are for services which meet the State's definition of an allowable medical expense and must be used to offset beneficiary liability in addition to paid claims totaling $70. The payment review computation is as follows:

$ 115 Liability Understated Amount

- 115 Denied Claims of $45, plus paid claims of $70

$ 0 Liability Met During Review Month

If the beneficiary had not erroneously received a Medicaid card he would have met his liability in the review month of June by incurring medical expenses of $115. Therefore, the case finding remains liability understated, and $70 (the amount erroneously paid by Medicaid) is the amount of misspent funds.

Had the denied claims not been considered during the payment review computation only the $70 in paid claims would have been deducted from the unmet liability amount of $115. The beneficiary would still have had $45 unmet liability as of the review month, and the case would have erroneously been found ineligible. The amount of misspent funds would not have changed.

EXAMPLE 10 - ORIGINAL FINDING OF LIABILITY UNDERSTATED $200 CHANGES TO INELIGIBLE. ONE CLAIM FOUND TO BE THE RESPONSIBILITY OF A THIRD PARTY: NOT USED TO REDUCE BENEFICIARY LIABILITY

In a one-month spend down State MEQC reviews a case for September and finds a liability understated error of $200 due to undercounted income. Three claims are paid for the review month of $110, $25 and $100. Review reveals that $80 of the $100 claim was the responsibility of a third party. Therefore, MEQC assumes that even if the beneficiary had not erroneously received a Medicaid card he/she would not have incurred the total claim for $100. Therefore, in the payment review computation only $20 of the $100 claim actually incurred by the beneficiary can be used to meet liability as follows:

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$ 200 Liability Understated Amount

- 110 Paid Claim for September

$ 90

- 25 Paid Claim for September

$ 65

- 20 (September Claim of $100 less $80)

$ 45 Unmet Liability as of Review Month

The case is ineligible and the full amount of actual Medicaid paid claims in the review month ($235) is misspent. The original State finding of liability understated will be changed to ineligible and the payment review will show $235 in misspent funds.

If the total claim of $100 had been used during the payment review to offset beneficiary liability rather than only the $20 not the responsibility of a third party, liability would have been met during the review month and the finding would have erroneously remained liability understated with $200 in misspent funds.

EXAMPLE 11 - ORIGINAL FINDING OF ELIGIBLE CHANGES TO INELIGIBLE; THIRD PARTY PAID TOTAL HOSPITAL BILL

MEQC reviews an SSI-related case in a one-month spend down State and finds that the agency correctly computed the beneficiary's liability ($250) for the review month of May. The case record indicates that the beneficiary came in to apply for Medicaid on May 1 and was informed that he must incur $250 in medical expenses to offset his excess income. The beneficiary was hospitalized from May 2 to 6. Upon release from the hospital he presented the hospital bill to the Medicaid agency and was informed that he was responsible for the first $250 (incurred May 2-3), and Medicaid would cover the remainder of the bill (incurred May 4-6). The MEQC file contained evidence that the beneficiary was covered by an insurance policy which may pay for the cost of hospitalization.

The potential for misspent Medicaid funds is carefully examined during the payment review since the portion of the hospital bill incurred after the beneficiary became eligible for Medicaid (May 4-6) was not paid by Medicaid. MEQC verifies that the third party paid the entire hospital bill and there were no other incurred medical expenses. The only paid review month claims were a physician's claim of $30 and four prescriptions totaling $40. The payment review computation is as follows:

$ 250 Actual Recipient Liability

- 30 Paid Physician's Claim

$ 220

- 40 Four Paid Pharmacy Claims

$ 180 Unmet Liability as of Review Month

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Since the correctly computed liability was not met during the review month the original State finding of eligible must be changed to ineligible, and the payment review will show $70 in misspent funds.

EXAMPLE 12 - ORIGINAL FINDING OF LIABILITY UNDERSTATED WITH INELIGIBLE MEMBERS CHANGES TO ELIGIBLE WITH INELIGIBLE MEMBERS

In a 6-month spend down State MEQC reviews an AFDC-related case consisting of a mother and three children for October and finds that one of the children is ineligible. The child turned 21 in May. The mother and two children under 21 in the case are eligible as AFDC-related. MEQC establishes that the mother has $237.50 monthly income.

The date of application was June 5 and the original unit of four persons had excess income of $100 for the period of June-November which was offset immediately by dental expenses incurred by the mother during the first 4 days of June.

The case must be reevaluated by MEQC using the same spend down period established by the agency to compute liability. Since the change in circumstances causing the error (child turning 21) occurred prior to the date of application liability for the three remaining case members must be established for this period. Due to a lower medically needy income level for three persons MEQC finds the beneficiary liability to be understated by $125. The computation is as follows:

$ 237.50 Monthly Income (mother and two children under 21)

- 200.00 Medically Needy Income Level - three persons

$ 37.50 Monthly Excess

x 6 Months

$ 225.00 Excess Income

- 100.00 Dental Expense Previously Incurred

$ 125.00 Actual Liability Understated Amount

When Medicaid paid claims are assembled for June-October services during the payment review MEQC finds that claims of $135 were paid for the mother and two children under 21 prior to the review month. Claims totaling $570 were paid for the ineligible child, $170 of which was paid during the review month of October.

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June July Aug. Sept. Oct. Nov.

(Review

Month)

Medicaid Paid

Claims for Mother

and Two Children

Under 21 $ 40 $ 50 $ 20 $ 25 $ 0 $ -

Medicaid Paid

Claims for

Ineligible Child 0 0 0 400 170 -

The payment review computation is as follows:

$ 125 Actual Liability Understated Amount

(Mother and two children under 21)

- 40 June Paid Claim

$ 85

- 50 July Paid Claim

$ 35

- 20 August Paid Claim

$ 15

- 25 September Paid Claim

$ - 10 Liability Met Prior to Review Month

Note that since the ineligible child was not included in the determination of liability his claims will not be used to offset liability.

If a Medicaid card had not erroneously been issued to the 4-person assistance group September is the month in which the mother and two children under 21 would have met their liability. By the review month of October the mother and two children under 21 would have legitimately been eligible for Medicaid. Thus, there are no misspent funds for this group in October. The original case finding of liability understated with ineligible members must be changed to eligible with ineligible members. The amount of misspent funds for the case is $170, the total amount of review month claims paid for the ineligible case member.

EXAMPLE 13 - BILLED AMOUNTS USED TO OFFSET LIABILITY; ONE CLAIM FOR REVIEW MONTH SERVICES

The agency computed a $400 spend down for the beneficiary on June 1 which he immediately met and was certified eligible for June 1 - November 30 (6-month spend down

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State). MEQC reviews the case for June and finds that the beneficiary's income increased prior to June, and he has not incurred any additional expenses to offset the excess income. MEQC computes a spenddown of $500. Four hundred dollars of liability was met June 1 leaving liability understated error of $100.

$ 500 Actual Liability

- 400 Already Met

$ 100 Liability Understated Error

During the payment review MEQC finds that one claim was billed and paid for June services. MEQC uses the $90 billed amount to offset liability since this State chose the sampling plan option of utilizing billed amounts to offset excess income. The beneficiary would not have incurred sufficient medical expenses to offset the liability during the review month so the $100 liability understated finding is changed to ineligible in the payment review.

June

Medicaid Billed Amount $ 90

Medicaid Paid Claims $ 80

The misspent dollars can never exceed the dollar amount of paid claims. In this case $90 was billed for review month services, and Medicaid paid $80 of the claim. Since the case is ineligible the dollar error is $80, the full amount of review month paid claims.

EXAMPLE 14 - BILLED AMOUNTS USED TO OFFSET LIABILITY; MULTIPLE CLAIMS FOR REVIEW MONTH SERVICES

Had this same example been selected in July the unmet liability for the July review month would have been $10.

$ 100 Liability Error

- 90 June Billed Amount

$ 10 Liability Unmet Prior to July Review Month

When MEQC collects claims they find that several claims were billed and paid for July services.

June July 1 July 15 July 29

Medicaid Billed Claims 90 8 10 30

Medicaid Paid Claims 80 6 9 25

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MEQC must use the billed amount to offset excess income in the order incurred to determine the correct amounts of misspent dollars.

Liability Still Billed Used to Offset Paid Dollar

To Be Incurred Amount Liability Amount Error

July 1 Claim $ 10 $ 8 $ 8 $ 6 $ 6

July 15 Claim 2 10 2 9 1

July 29 Claim 0 30 0 25 0

7

If the agency had not erroneously issued a Medicaid card on June 1 the liability would have been met in July. The beneficiary would have been responsible for the $8 (July 1) claim. Since Medicaid paid $6 for this claim which was the full responsibility of the beneficiary, $6 was paid in error. The beneficiary would have been responsible for $2 of the $10 (July 15) claim at which point he would have become eligible for Medicaid. The provider could have billed Medicaid for the difference ($10-$2 beneficiary liability = $8). Since Medicaid paid $9 for the July 15 claim when no more than $8 should have been paid, $1 of the July 15 claim was paid in error. The final finding on this case is liability understated with a dollar error of $7.

NOTE: In States with reimbursement policies dictating a reasonable charge limitation (i.e., the provider cannot be reimbursed for more than the Medicaid rate including recipient liability), QC must review against this policy. In this example the dollar error for the $10 claim would have been $2 ($9 Medicaid reimbursement rate - $2 beneficiary liability = $7 correct amount; $9 Medicaid claim - $7 correct amount = $2 error). The total dollar error for the case would then be $8.

7333. DETERMINING FINAL MISSPENT DOLLAR AMOUNTS OF INSTITUTIONAL CASES

The review of institutional cases differs from non institutional cases because eligibility/liability is determined by a two-step process. The reviewer must first determine whether the beneficiary is eligible and then determine the amount to be applied to the cost of care. During the payment review the institutional billing must be reviewed to determine whether the appropriate amount was applied to the cost of care. The agency could incorrectly compute the patient's contribution towards his/her cost of care, and the institution could correctly adjust for the patient's contribution. In this situation the initial eligibility finding would be liability over- or understated, and the payment review finding would be eligible with no dollar error. Conversely, the agency may correctly compute the patient's contribution to the cost of care (i.e., the initial finding is eligible), and the nursing home may incorrectly adjust this amount when billing Medicaid. Thus,

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Medicaid would pay an incorrect amount. In this situation the final case finding would be either liability understated (with a dollar error) or liability overstated (with no dollar error). Errors resulting from an incorrect institutional billing should be coded in element 550 (other State Medicaid criteria), nature code 097 (incorrect claims billing increased/decreased liability).

All policies described in §7330 apply to institutional cases with liability understated errors. These procedures also apply to institutional cases when the institutional billing is not present in the review month claims.

EXAMPLE 1 - ORIGINAL FINDING OF ELIGIBLE CHANGES TO LIABILITY UNDERSTATED: NURSING HOME BILLS INCORRECT AMOUNT AND MEDICAID PAYS THIS AMOUNT

MEQC reviews the institutional case and determines that the agency correctly computed the beneficiary's contribution toward his cost of care as $650. The initial MEQC finding is eligible. During the payment review MEQC finds that the nursing home cost was $1,000. The nursing home incorrectly applied only $600 of the beneficiary's income toward his cost of care. Medicaid was billed and paid $400 for the nursing home care.

Nursing Home Billing MEQC Computation

$ 1,000 Total Cost of Care $ 1,000 Total Cost of Care

- 600 Applied to Cost of Care - 650 Correct Contribution

to Cost of Care

$ 400 Paid by Medicaid $ 350 Amount Medicaid Should

Have Paid

Correct Contribution to Cost of Care $ 650

Contribution Applied to Cost of Care

    by Nursing Home - 600

Liability Understated Error $ 50

The initial finding of eligible is changed to liability understated and the dollar error is $50.

EXAMPLE 2 - ORIGINAL FINDING OF LIABILITY UNDERSTATED CHANGES TO ELIGIBLE: NURSING HOME CORRECTLY ADJUSTS LIABILITY

In this nursing home case MEQC finds, during the eligibility review, that the agency failed to adjust for an OASDI increase. The review month is October, and MEQC finds an initial liability understated error of $29. The beneficiary has not incurred any additional medical expenses.

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Cost of Care Computation

Agency MEQC

OASDI Income $ 550 $ 579

Personal Needs Allowance - 25 - 25

Amount To Be Applied to

    Cost of Care $ 525 $ 554

Liability Understated Amount = $29 ($554 MEQC computation - $525 agency

computation)

During the payment review MEQC finds that the nursing home took into consideration the OASDI increase and correctly adjusted the amount to be applied toward the cost of care.

Nursing Home Billing

$ 1,000 Nursing Home Cost

- 554 Beneficiary's Income Applied To The Cost of Care

$ 446 Billed and Paid by Medicaid

Since the nursing home correctly adjusted the amount of the beneficiary's income to be applied to the cost of care the final finding is changed to eligible with no dollar error.

7336. IDENTIFYING THE PRIMARY ELIGIBILITY AND LIABILITY ERRORS

The MEQC review determines all the eligibility and liability errors occurring in a sampled case and records up to nine of these in section VI of the IRS. For each sampled case found to be ineligible or to have ineligible member(s) or to have a liability error, determine the error that contributed most substantially to the liability error or to the ineligibility. If the QC worksheets indicate that more than one error contributes to the ineligibility or inaccurate computation, select the primary error. Code errors in terms of the impact the error had on the case. Use the following criteria:

1. If all members of a case have both an eligibility and liability error the eligibility error is overriding.

a. If case liability has been computed incorrectly and each member of the case failed to meet an element of eligibility the case is ineligible and all claims paid for the case members during the review month were paid in error unless ineligibility is a result of excess resources. In those cases count the lesser amount of paid claims or excess resources. Classify the error as an eligibility error.

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b. If case liability has been computed incorrectly and any case members are found ineligible all claims paid for the ineligible case member(s) during the review month were paid in error unless the ineligibility is caused by resources in which case the amount of claims paid in error could not exceed the amount of excess resources. For the remaining eligible member(s) all paid claims up to the final understated liability amount were paid in error.

2. If an understated or overstated liability case is found to have multiple errors the liability error listed first in section VI of the IRS is the primary error. Only one primary error can be associated with a case liability error.

If beneficiaries in a case are ineligible for different primary errors record these errors separately in section VI of the IRS in descending order with the greatest error dollar amount first. If the number of beneficiaries and the number of primary errors exceed nine, combine the error dollar amounts for the fifth and any additional beneficiaries into a single error dollar amount.

3. If the case is eligible but a member(s) of the case has received services for which he was not eligible it is considered an eligibility error rather than a claims collection error. See §7312 for a discussion of this type of error.

7339. DEFINITION OF MISSPENT DOLLAR AMOUNTS FOR CASES CONTAINING FINAL ELIGIBILITY OR LIABILITY ERRORS

The dollar amount of eligibility or liability errors is related to the dollar amount of the claims for services provided to ineligible members, to a case with a final finding of understated liability during the review month, or to eligible beneficiaries who have received ineligible services. Follow these instructions in determining the dollar amount of each type of error.

In cases with multiple errors the overall dollar amount of error is determined as follows.

1. If at least one error is an eligibility error (other than for excess resources) the dollar amount of error is the full amount of paid claims for the ineligible beneficiary(ies), or the amount of ineligible services received, as applicable.

2. In those cases where both eligibility and liability errors exist the case must be redefined and reevaluated. To reevaluate the case the reviewer first removes the ineligible case members from the case, then reevaluates the eligibility and, if appropriate, recomputes the liability of remaining case members. The total amount of misspent dollars will be calculated by combining the amount of dollars in error for ineligible beneficiaries and/or services with the amount of dollars determined to have been misspent because of the initial liability understated finding.

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Record the dollar amount of eligibility and liability errors by primary type of error on the IRS. In cases with multiple beneficiaries with mixed eligibility findings compute the first dollar error amount paid on behalf of ineligible beneficiaries. List each element in error and the combined dollar error amounts for all ineligible beneficiaries having this same primary error. On the IRS code the eligibility and liability errors in separate blocks and then combine the dollar error amounts to show the total dollar error. If all beneficiaries in a case are found to be ineligible due to the same type of error record the overall case dollar eligibility error amount on the IRS as the dollar error amount recorded with the primary error for the case. Then record the primary liability error and the dollar amount.

Compute from these gross dollar amounts of eligibility and liability errors by primary type of error the total dollar amount of misspent funds by combining the dollar amounts of error for all ineligible recipients with the dollar amount of any misspent funds paid on behalf of the case members with a final finding of understated liability.

7342. COMPLETING THE UNDUPLICATED DOLLAR ERROR AMOUNT WORKSHEET (OPTIONAL)

Computations of final dollar errors may be completed on this worksheet for each case in which the original finding is subject to change. A sample worksheet is shown in §7342.1. Exhibit 4 allows the reviewer to record the following:

1. Case and beneficiary name(s),

2. Claim number and date of service provision (when utilizing paid claims to offset beneficiary liability errors arrange claims in order of dates of service),

3. Amount paid, and

4. Final payment review computation indicating whether beneficiary liability was met prior to the review month, during the review month, or not at all.

The use of the worksheet when computing the final dollar amount of eligibility/liability errors and determining the final case finding is optional. However, if this worksheet is not used record the same information on a form devised by the State or on plain paper and include in the MEQC file.

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|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Exhibit 4  Unduplicated Dollar Error Amount Worksheet | | | | | | | | | | | |
|  | | (a) | (b) | (c) | (d) | (e) | (f) | (g) | (h) | (i) |
| Bene Name. | I.D. No | Elig. Errors Other Than For Excess Resources And Technical errors | Excess Resources Errors | Understated Liability Error | Overstated Liability Error | Technical Error | Eligible With Ineligible Services Error | Gross Countable Error (add and unduplicate cols a, b, c, d, and f). | Paid Claims Amount | Net Error  Lesser of Col. g or h |
|  |  |  |  |  |  |  |  |  |  |  |
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TOTALS

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7343. COMPUTATION OF ERROR AMOUNTS FOR CASES INVOLVING

BENEFICIARIES DUALLY ELIGIBLE FOR QMB AND NON-QMB COVERAGE

GROUP

Beginning in January 1989, under §§1902(e)(8) and 1905(p)(1) of the Act, a single individual may be dually eligible for Medicaid as a QMB and under a non-QMB Medicaid eligibility coverage group at the same time. HCFA refers to these cases as QMB/non-QMB cases. When these cases are reviewed, MEQC may identify errors in either or both of these eligibility coverage groups. In addition, the types of errors may be the same for both coverage groups, i.e., both eligibility errors, or they may be different, i.e., one eligibility error and one liability error. To determine the dollar amount of any errors in these cases, the usual MEQC rules for error calculations are applicable for these dually eligible cases. This section provides examples of how these rules apply to dually eligible (QMB/non-QMB) cases.

When errors occur in an MEQC sampled QMB/non-QMB case, identify whether the paid claims are QMB covered only, non-QMB covered only, covered under both coverage groups, or unclassifiable. Only claims that can be covered under the group for which the client is eligible are eligible payments. Therefore, it is critical that the MEQC reviewer identify the coverage group(s) under which the claims for the MEQC review month are covered. In QMB/non-QMB error cases, determine the error amount using only the claims that cannot be covered under the eligible group. See examples 1.A. and 1.B. in §7343.5. If you cannot identify the coverage group(s) under which the individual claims can be covered, consider the unclassifiable claims to be paid under the group with the error. See example 1.C.

For the purpose of determining the eligibility group under which claims can be covered, some things are beyond the scope of the MEQC payment review for dually eligible QMB/non-QMB cases. These include:

o Errors in the amount of claims payment due to failure to use available third party coverage, such as incorrect payment in full of a hospital claim which could have been paid partially by Medicare Part A. Consider this claim a QMB-covered claim even though only the Medicare cost sharing amount should have been paid.

o Determination of whether a provider of a medical service on a dually QMB/non-QMB case is a Medicare/Medicaid provider or a Medicare only provider. Assume that the claims paid for any provider are covered under both coverage groups if the claims are (1) for services covered under the State plan for the Medicaid non-QMB coverage groups, and (2) for services eligible for payment under Medicare.

o Determination of correctness of amount of payment based on program (Medicare/Medicaid) participation of the provider.

7343.1 Coding of QMB/Non-QMB Cases on Integrated Review Schedule (IRS). Generally, the coding of QMB/non-QMB on the IRS follows the same guidelines as for other MEQC sampled cases. However, some of the National Integrated Quality Control System (NIQCS) edits have been deleted for QMB/non-QMB cases to allow coding of multiple types of errors and to allow changing of some previously reported initial coding when the MEQC payment review findings are reported. Use the directions in the IRS manual and the following guidelines for QMB/non-QMB cases.

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If the MEQC initial findings indicate that the case is eligible for one of the groups but has an error other than total ineligibility for the other coverage group, use the coverage code for dual eligibility (12) at the end of the eligibility review. The coverage code may be changed at the end of the MEQC payment review, if necessary. See example 5 in §7343.5.

If there are distinctly different types of errors in QMB and the non-QMB group, use a summary code to define the eligibility status in the Initial Case Eligibility Status and Final Case Eligibility Status on the IRS. Separate the errors in the Detailed Error Findings of the IRS. The error finding codes may be different from the Initial or Final Case Eligibility Status. For example, if the case finding is ineligible under QMB and understated liability under non-QMB, the Initial Case Eligibility Status code indicates understated liability with ineligible services. The detailed error finding indicates an understated liability for the non-QMB error element and ineligible for the QMB error element.

If distinctly different types of errors are found in the same element for QMB and non-QMB, the same element number may be listed on multiple lines of the detailed error finding. For example, if the error from unreported income causes the case to be ineligible under QMB and also causes an understated liability under non-QMB, code the element number on two lines with a liability error indicated on one line and an eligibility error indicated on the other line.

Optional new codes have been added for program identifiers to allow you to specify whether the individual error occurred under QMB coverage or under non-QMB coverage on a dually eligible QMB/non-QMB case. Federal tables do not display these findings separately. However, they are available to develop State reports using this additional information for corrective action. For example, using the findings above, the State may choose to use the QMB program identifier for the eligibility error and use the non-QMB program indicator for the understated liability error, or continue to use the generic Medicaid program identifier for both errors. For the Federal 6 month summary reports, combine the separate program identifiers into the generic Medicaid program identifier.

7343.2 Dually Certified Cases - Ineligibility for One Coverage Group Due to Excess Resources.--When a dually eligible QMB/non-QMB beneficiary is eligible for one of the coverage groups but ineligible for the other coverage group because of excess resources, determine the payment error amount by comparing the excess resources to the paid claims as described below and in §7315. Count as eligible those claims that can be identified as covered under the eligible coverage group. Determine the error amount as the lesser of (1) the excess resources, or (2) the amount of the claims that can be identified as covered ONLY under the ineligible group plus all the unclassified claims. (See §7343.5, example 3.)

7343.3 Ineligibility for Both Coverage Groups Due to Excess Resources.--When a dually eligible QMB/non-QMB beneficiary is ineligible due to excess resources for both QMB and the non-QMB coverage group, begin the determination of the error amount by identifying the coverage group under which the claims can be covered (i.e., QMB, non-QMB, or both).

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Identify the coverage group that has the lower excess resource amount and designate it as Group A. If both groups have the same amount of excess resources, identify as Group A the one which has the larger amount of claims covered under that group. If these totals are the same, identify QMB as the A group.

Step 1: Determine the lesser amount of (1) the claims for Group A only plus the both claims, or (2) the excess resource amount for Group A.

Step 2: Determine the lesser amount of (1) the non-A group only claims plus the unclassifiable claims, or (2) the excess resource amount for the non-A group.

The final error amount is the lesser of the sum of the amounts in steps 1 and 2 or the higher amount of excess resources (non-A group).

7343.4 Understated Liability for Non-QMB Group.--When a dually eligible QMB/non-QMB beneficiary has an understated liability (UL) for the non-QMB coverage group, use these guidelines and those in §7330 to determine whether to reduce the initial UL amount. Determining whether QMB certification was correct during the spenddown period prior to the MEQC review month is beyond the scope of the MEQC review for purposes of applying prior month claims to the spenddown amount. Therefore, for all months of the spenddown period in which the recipient was certified as QMB, apply only non-QMB prior month claims to the UL. Furthermore, treat any unclassifiable claims as QMB-covered claims. For the months of the spenddown period in which the recipient was NOT certified for QMB, apply all claims to the outstanding liability during the spenddown period prior to the review month. (See examples 5.B and 6.B in §7343.5.)

If the initial UL amount is reduced to $0 by applying prior month claims, determine the dollar amount of the error as follows:

A. If the case is eligible as QMB for the MEQC review month, the dollar amount of the error is $0.

B. If the case is ineligible for QMB for the MEQC review month,

1. Count non-QMB claims as eligible, and

2. Count as ineligible those claims that can be covered ONLY under QMB, plus all unclassifiable claims. (See example 6.B in §7343.5.)

If the initial UL amount is not reduced to $0:

A. If the recipient is eligible for QMB for the review month, use the MEQC review month claims covered under QMB to establish the final status of the liability error according to §7330. (See example 5.B in §7343.5.)

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B. If the recipient is ineligible for QMB for the MEQC review month due to a reason other than excess resources, use all the MEQC review month claims to determine the final status of the liability error according to §7330. Apply the unmet liability to the review month claims in date of service order. For single dates of service with multiple claims, apply the unmet liability to QMB ONLY and unclassifiable claims first if these claims would be the recipient's responsibility if they were not eligible for payment under Medicaid.

1. If the revised initial UL amount is met in the review month, the maximum amount of the liability error is the revised initial UL amount for the review month. To unduplicate the error dollars and allot the dollar amount of final error to the proper error category:

(a) Determine the eligibility error amount to show on the IRS, in the final dollar amount of case eligibility errors, as the amount of claims that can be identified as covered ONLY under QMB plus the unclassifiable claims, and

(b) Determine the liability error amount, to show on the IRS, in the final dollar amount of case liability errors, as (1) the revised initial USL amount minus (2) the dollar amount of the QMB ONLY and unclassifiable claims used to offset the liability. This may reduce the UL to $0. (See §7343.5, example 6.B.)

2. If the revised initial USL amount is NOT met in the review month, determine the dollar amount of the eligibility error as the total amount of the paid claims for the review month. (See §7343.5, example 6.B.)

7343.5 Examples of Error Computations for Qualified Medicare Beneficiary Coverage.--The examples below demonstrating how to determine the coverage group(s) under which particular services are covered are for illustration only. Make these decisions based on coverage groups included in your State plan.

EXAMPLE 1: MEQC finding of eligible for QMB but ineligible under non-QMB coverage for a reason other than excess resources.

A. Some Paid Claims Can Be Covered Only Under The Non-QMB Coverage Group.-Determine the coverage group(s) to assign the review month claims.

Total Non-

Claims QMB Both QMB Unclassifiable

Physician crossover $ 12 $12

Dental 79 $79

Drugs 96 96

Medicare B buy-in for CN 27 27

Medicare A buy-in 156 $156

$370 $175 $39 $156 0

Since the claims identified as QMB-covered claims are eligible for payment, determine the error amount as the amount of paid claims covered ONLY under the non-QMB group plus the unclassifiable claims.

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Non-QMB only $175

Unclassifiable claims -0-

Total errors $175

B. All Paid Claims Are QMB-Covered.--Determine the coverage group(s) to assign the review month claims.

Total Non-

Claims QMB Both QMB Unclassifiable

Physician crossover $ 12 $12

Medicare B buy-in for CN 27 27

Medicare A buy-in 156 $156

$195 0 $39 $156 0

Since all the claims are identified as eligible for payment under the eligible QMB group, the dollar amount of the eligibility error is $0.

C. Claims Not Classified By Coverage Group.--Determine the coverage group(s) to assign review month claims.

Total Non-

Claims QMB Both QMB Unclassifiable

Claim A $ 12 $ 12

Claim B 79 79

Claim C 96 96

Medicare buy-in 27 $27

$214 0 $27 0 $186

If you cannot distinguish the coverage group(s) under which some of the individual claims can be paid, assume that the unclassifiable claims were paid under the coverage group with the error. Determine the error amount as the amount of the paid claims for the ineligible non-QMB group plus the unclassifiable claims.

Non-QMB only claims $ 0

Unclassifiable 187

Total error $187

EXAMPLE 2: MEQC finding of ineligible for QMB for a reason other than excess resources but eligible under non-QMB coverage.

A. Paid Claims Covered Only Under QMB.--Determine the coverage group(s) to assign review month claims.

Total Non-

Claims QMB Both QMB Unclassifiable

Physician crossover $ 30 $30

Drugs 22 $22

Medicare B buy-in for MN 27 $27

$ 79 $22 $30 $27 0

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Since the non-QMB identified claims are eligible for payment, determine the error amount as the amount of the claims identified as covered only under QMB plus the unclassifiable claims as follows:

QMB only claims $ 27

Unclassifiable 0

Total error $ 27

B. QMB-Only Paid Claims.--Determine the coverage group(s) under which the MEQC review month claims can be covered

Total Non-

Claims QMB Both QMB Unclassifiable

Physician crossover $ 30 $30

Medicare B buy-in for CN 27 $27

$ 57 0 $27 $30 0

Since all the claims are identified as eligible for payment under the non-QMB coverage group, the dollar amount of the eligibility error is $0.

EXAMPLE 3: MEQC finding of eligible for QMB but ineligible under another non-QMB coverage group because of $150 excess resources.

A. Paid Claims For The Non-QMB Coverage Group Are Greater Than The Excess Resources.--Determine the coverage group(s) under which the MEQC review month claims can be covered.

Total Non- Claims QMB Both QMB Unclassifiable

Physician crossover $ 12 $12

Dental 79 $ 79

Drugs 96 96

Medicare B buy-in for CN $ 27 27

$214 $175 $39 0 0

Since the identified QMB-covered claims are eligible for payment, determine the error amount as the lesser of the (1) excess resources or (2) the non-QMB only claims plus the unclassifiable claims as follows:

Unclassifiable claims $ 0

Non-QMB only claims 175

Total $175

Excess Resources $150 = lesser amount

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Note that the amount of error in this case is the lesser of excess resources or paid claims.

B. Paid Claims for the Non-QMB Coverage Group are Less Than the Excess Resources.--Determine the coverage group(s) to assign review month claims.

Total Non

Claims QMB Both QMB Unclassifiable

Physician crossover $ 12 $12

Dental 69 $ 69

Drugs 41 41

Medicare B buy-in for CN

Since the identified QMB-covered claims are eligible for payment, determine the error amount as the lesser of (1) the excess resources or (2) the non-QMB only claims plus the unclassifiable claims as follows:

Unclassifiable claims $ 0

Non-QMB only claims 110

Total $110 (lesser amount)

Excess Resources $150

Since the amount of claims is less than the excess resources, the amount of error is $110.

C. All Paid Claims are QMB-Covered.--Determine the eligibility group(s) to assign review month claims.

Total

Claims Non-QMB Both QMB Unclassifiable

Physician crossover $12 $12

Medicare B buy-in for CN 27 \_\_\_\_\_ 27

$ 39   0 $39   0    0

Since all the claims are eligible for payment under the eligible QMB group, the dollar amount of the eligibility error is $0.

D. Some Claims are Unclassifiable.--Determine the eligibility group(s) to assign the review month claims.

Total

Claims Non-QMB Both QMB Unclassifiable

Claim A $ 12 $12

Claim B 21 21

Medicare B buy-in for CN 27 $27

Medicare A buy-in 156 \_\_\_\_ $156

$216 0 $27 $156   $33

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Since the QMB-covered claims are eligible, determine the error amount as the lesser of (1) the excess resources or (2) the non-QMB ONLY claims plus the unclassifiable claims as follows:

Non-QMB only claims $ 0

Unclassifiable claims 33

Total $ 33 lesser amount

Excess Resources $150

Since the amount of claims is less than the excess resources, the amount of the error is $33.

EXAMPLE 4: MEQC finding of ineligible for QMB due to excess resources and ineligible under another non-QMB coverage group due to excess resources.

A. QMB Excess Resources of $100 and Non-QMB Excess Resources of $500.--Determine the coverage group(s) to assign the review month claims.

Total

Claims Non-QMB Both QMB Unclassifiable

Physician crossover $ 87 $ 87

Drugs 40 $40

Drugs 27 27

Medicare B buy-in for CN 156 \_\_\_ $156

$310 $40   $114 $156    0

Determine the coverage group which has the lower excess resources and designate that as group A.

QMB excess resources $100 lesser amount (Group A)

Non-QMB excess resources $500

STEP 1: Determine the lesser amount of (1) the claims for Group A only plus the both claims or (2) the excess resource amount for Group A.

QMB only claims $156

Both claims +114

$270

QMB excess resources $100 lesser amount

STEP 2: Determine the lesser amount of (1) the non-A group only claims plus the unclassifiable claims or (2) the excess resource amount for the non-A group.

Non-QMB only claims $ 40

Unclassifiable claims 0

$ 40 lesser amount

Non-QMB excess resources $500

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Determine the final error amount as the lesser of (1) the lesser amount determined in Step 1 plus the lesser amount determined in Step 2 or (2) the higher amount of excess resources.

Step 1 lesser amount $100

Step 2 lesser amount +40

$140 lesser amount

Higher excess resources $500

Since the Step 1 lesser amount plus Step 2 lesser amount is less than the higher excess resources, the amount of the error is $140.

B. QMB Excess Resources of $400 and Non-QMB Excess Resources of $200.--

Determine the coverage group(s) to assign the review month claims.

Total

Claims Non-QMB Both QMB Unclassifiable

Medicare B buy-in for MN $ 27 $27

Physician crossover 40 $40

Dental 280 $280

Drugs 160 160

Claim A 100 $100

$607 $440   $40 $27 $100

Determine the coverage group which has the lower excess resources and designate that as group A.

QMB excess resources. $400

Non-QMB excess resources. $200 lesser amount (Group A)

Step 1: Determine the lesser amount of (1) the claims for Group A only plus the both claims or (2) the excess resource amount for Group A:

Non-QMB only claims $440

Both claims +40

$480

QMB excess resources $200 lesser amount

Step 2: Determine the lesser amount of (1) the non-A group only claims plus the unclassifiable claims or (2) the excess resource amount for the non-A group.

QMB only claims $ 27

Unclassifiable claims +100

$127 lesser amount

QMB excess resources $400

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Determine the final error amount as the lesser of (1) the step 1 lesser amount plus the step 2 lesser amount or (2) the higher amount of excess resources.

Step 1 lesser amount $200

Step 2 lesser amount 127

$327 lesser amount

Higher excess resources $400

Since the step 1 lesser amount plus the step 2 lesser amount is less than the high excess resource, the amount of the error is $327.

C. QMB Excess Resources of $100 and Non-QMB Excess Resources of $500.--Determine the coverage group(s) to assign the review month claims.

Total Non-

Claims QMB Both QMB Unclassifiable

Medicare A buy-in $ 156 $156

Physician crossover 33 $ 33

Medicare B buy-in for CN 27 27

Hospital crossover 560 $560

Drugs 670 $670

$1446 $670 $620 $156 0

Determine the coverage group which has the lower excess resources and designate that as group A.

QMB excess resources $100

Non-QMB excess resources $500

Step 1: Determine the lesser amount of (1) the claims for Group A only plus the both claims or (2) the excess resource amount for Group A:

QMB only claims $156

Both claims 620

$776

QMB excess resources $100 lesser amount

Step 2: Determine the lesser amount of (1) the non-A group only claims plus the unclassifiable claims or (2) the excess resource amount for the non-A group.

Non-QMB only claims $670

Unclassifiable claims 0

$670

Non-QMB excess resources $500 lesser amount

Determine the final error amount as the lesser of (1) the Step 1 lesser amount plus the Step 2 lesser amount or (2) the higher amount of excess resources.

Step 1 lesser amount $100

Step 2 lesser amount 500

$600

Higher excess resources $500 lesser amount

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Since the higher excess resource is less than the Step 1 lesser amount plus the Step 2 lesser amount, the amount of the error is $500.

EXAMPLE 5: Eligible for QMB and understated liability (UL) OF $100 for non-QMB eligibility group

A. All the Review Month Claims Can Be Covered Under QMB.--Determine the coverage groups to assign the review month claims.

Total Non-

Claims QMB Both QMB Unclassifiable

Physician crossover $ 12 $12

Medicare B buy-in for MN 27 $27

Total $ 39 0 $12 $27 0

Since all the review month claims are identified as covered under the eligible QMB group, the dollar amount of the error is $0.

B. Some of the Review Month Paid Claims Are Covered Only Under the Non-QMB Eligibility Group or are Unclassifiable.--Determine whether to reduce the initial liability error using instructions in §7330 and the following guidelines. For the prior months in the certification period (CP) for which QMB was certified, apply the UL review to claims identified as covered only under the non-QMB eligibility group. For the prior months in the CP for which QMB was not certified, apply the UL review to all the claims. Determination of the correctness of the QMB certification in the prior months of the CP is beyond the scope of the MEQC review.

For example, for a CP of August 1989 - January 1990 when the MEQC review month is October, 1989, reduce the initial UL of $100 as follows:

Total Non- For UL

Month Certified for Paid Claims Claims QMB Both QMB Review

8/89 Non-QMB only Physician

crossover $ 15 $15

9/89 Dual QMB and Physician

Non-QMB crossover $ 25 $25 No

Drugs $ 18 $18 Yes

Medicare B

buy-in $ 27 $27 No

Drugs $ 12 $12 Yes

Initial UL $100

Prior month claims 45

Revised initial UL $ 55

C. If some of the review month claims are eligible for payment under QMB and non-QMB claims plus unclassifiable claims for the review month are greater than the revised initial UL of $55, then the status for the non-QMB group remains as UL.

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Determine the coverage group(s) to assign the review month claims.

Total Non-

Claims QMB Both QMB Unclassifiable

Physician crossover $ 12 $12

Dental 69 $ 69

Drugs 81 81

Medicare B buy-in for MN 27 27 $27

$189 $150 $39 $27 0

Since the identified QMB-covered claims are eligible for payment, determine whether the revised UL amount is met with the non-QMB only claims plus the unclassifiable claims for the MEQC review month per §7330.

Unclassifiable claims $ 0

Non-QMB only claims 150

Total $150

Revised initial UL $ 55 lesser

If the non-QMB only plus unclassifiable paid claims is greater than the revised UL, the final eligibility status of the non-QMB group is UL. The dollar amount of the liability error is the amount of the revised UL amount.

NOTE: The State may choose to use billed amounts and denied and noncovered claims as described in §7330.

D. If some of the review month claims are eligible for payment under QMB and non-QMB claims plus unclassifiable claims for the review month are less then the revised initial USL of $55, then the status for the non-QMB group changes to ineligible.

Assume the initial USL was reduced with prior month claims as shown in subsection B.

Determine the coverage group(s) to assign the review month claims.

Total Non-

Claims QMB Both QMB Unclassifiable

Physician crossover $ 12 $12

Drugs 30 $30

Medicare B buy-in for MN 27 $27

$ 69 $30 $12 $27 0

Since the identified QMB-covered claims are eligible for payment, determine whether the revised initial UL amount is met with the non-QMB only plus unclassifiable claims for the MEQC review month per §7330.

Unclassifiable $ 0

Non-QMB only claims 30

Total $ 30 lesser amount

Revised initial UL $ 55

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If the non-QMB only plus unclassifiable paid claims is less than the revised USL, determine the non-QMB group as ineligible and determine the dollar amount of the eligibility error as the amount of the non-QMB only plus unclassifiable claims. Change the final status to eligible with ineligible services for the MEQC review month and change the coverage code from dual eligibility to QMB only.

NOTE: The State may choose to use billed amounts and denied and noncovered claims as described in §7330.

E. Some claims are QMB-covered only with the initial UL reduced to $0 prior to the MEQC review month by the UL review. The final eligibility status of the non-QMB group is eligible.

For example, for CP August 1989 - January 1990 when the QC review month is October, reduce the initial UL of $100 as follows:

Total Non- For UL

Month Certified for Paid Claims Claims QMB Both QMB Review

8/89 Non-QMB only Hospital crossover $560 $560 Yes

Physician crossover 20 20 Yes

9/89 Dual QMB and Physician crossover 40 $40 No

Non-QMB

Initial UL $100

Prior months' claims -580

Revised UL 0

Determine the eligibility group(s) to assign the review month claims.

Total Non-

Claims QMB Both QMB Unclassifiable

Physician crossover $ 12 $12

Medicare B buy-in for MN 27 \_\_ $27

$ 39 0 $12 $27 0

Since the final eligibility status for both QMB and the non-QMB group is eligible, the dollar amount of error is $0.

EXAMPLE 6: Ineligible for QMB for a reason other than excess resources and UL of $100 for the Non-QMB coverage group.

A. All the Review Month Claims are Identified as Covered Only Under QMB.-Determine the coverage group(s) to assign the review month claims.

Total

Claims Non-QMB Both QMB Unclassified

Medicare A buy-in $156 $156

Medicare B buy-in for MN 27 27

$183 0 0 $183 0

Since all the review month claims are identified as covered only under the ineligible QMB group, the dollar amount of the eligibility error is the total amount of the claims.

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7343.5 (Cont.) REVIEW PROCESS 09-92

B. Some of the MEQC Review Month Paid Claims are Covered Only Under the Non-QMB Coverage Group.--Determine whether the initial liability error can be reduced using instructions in §7330 and the following guidelines. For the prior months in the CP, apply the UL review to claims that are covered only under the non-QMB eligibility group. For the prior months in the CP for which QMB was not certified, apply the UL review to all the claims. Determination of the correctness of the QMB certification in the prior months of the CP is beyond the scope of the MEQC review.

For example, for a CP of August 1989 - January 1990, when the MEQC review month is October, reduce the initial UL of $100 as follows:

Total Non- Use for

Month Certified for Paid Claims Claims QMB Both QMB UL Rev. 46

8/89 Non-QMB only Physician crossover $15 $15 Yes

9/89 Dual QMB and Physician crossover 25 $25 No

Non-QMB Drugs 18 18 Yes

Medicare B buy-in 27 $27 No

for MN 12 12

Dental 12 12

Initial UL $100

Prior months' claims 45

Revised initial UL $ 55

C. Some claims are covered only under the ineligible QMB group and the total claims for the MEQC review month are greater than the revised initial UL of $55 the status for the non-QMB group remains as UL.

Determine the eligibility group(s) to assign the review month claims:

Date of Total

Service Claim Claims Non-QMB Both QMB Unclassifiable

10-01 Medicare B buy-in $ 27 27

10-02 Drugs 10 10

10-06 Claim A 8 $ 8

10-06 Physician crossover 5 $5

10-18 Claim B 10 10

10-18 Dental 20 20

10-20 Medicare A buy-in 156 156

$236 $30 $5 $183 $18

Since the claims that are identified as QMB-covered only and unclassifiable claims are ineligible for payment, determine whether the revised UL amount is met using all the claims for the MEQC review month in §7330. Apply the unmet liability to the review month claims in date of service order. For single dates of service with multiple claims, apply the QMB only and unclassifiable claims to the unmet liability first if these claims would be the client's responsibility if they were not eligible for payment under Medicaid.

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Date of Type of Liability Still Paid Used to Offset

Service Coverage to Be Met Amount Liability

10-01 QMB only $ 55 $ 27 $ 27

10-02 Non-QMB 28 10 10

10-06 Unclassifiable 18 8 8

10-06 Both claim 10 5 5

10-18 Unclassifiable 5 10 5

10-18 Non-QMB 0 20 0

10-20 QMB only 0 156 0

NOTE: The State may choose to use the billed amounts and denied and uncovered claims as described in §7330.

If the paid claims are greater than the revised UL, the final eligibility status of the non-QMB group is UL. In order to unduplicate the error dollars, determine the dollar amount of the eligibility error as the total amount of the claims that can be covered only under QMB plus the unclassifiable claims. Determine the dollar amount of the liability error as the amount of the revised UL amount minus the dollar amount of the QMB only and unclassifiable claims that were used to offset the liability. If the amount of QMB only and unclassified claims used to offset the liability equals or exceeds the revised initial UL amount, the liability error amount is $0.

QMB only claims $183

Unclassifiable claims + 18

$201 eligibility error amount

Revised UL amount $ 55

QMB only used to offset

liability - 27

Unclassifiable claims used

to offset liability - 13

$ 15 liability error amount

D. Some paid claims are identified as covered only under the ineligible QMB and the total for the MEQC review month is less than the revised initial USL of $55 the status for the non-QMB group changes to ineligible.

Assume the initial UL was reduced to $55 by the QC review month (as described in subsection B).

Determine the coverage group(s) to assign the review month claims.

Date of Total

Service Claims Claims Non-QMB Both QMB Unclassifiable

10-08 Physician crossover $ 12 $12

10-01 Medicare B buy-in 27 $27

$ 39 0 $12 $27 0

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7343.5 (Cont.) REVIEW PROCESS 09-92

Since the claims that are identified as QMB only and unclassifiable are ineligible for payment, determine whether the revised UL amount is met using all the claims for the MEQC review month following directions in §7330. Apply the unmet liability to the review month claims in date of service order. For single dates of service with multiple claims, first apply the QMB only and unclassified claims to the unmet liability.

Date of Type of Liability Still Paid Used to Offset

Service Coverage to Be Met Amount Liability

10-01 QMB Only $55 $27 $27

10-08 Both claims 28 12 12

If the paid claims are less than the revised UL, the eligibility status of the non-QMB group is ineligible. Determine the dollar amount of the eligibility error as the total amount of the paid claims. Change the final eligibility status to ineligible for the QC review month.

E. Some claims are identified as covered only under the ineligible QMB and the initial USL for the non-QMB coverage group is reduced to $0 prior to the MEQC review month by the UL review so the final eligibility status of the non-QMB group is eligible.

For example, for CP August 1989 - January 1990 when the QC review month is October, reduce the initial UL of $100 as follows:

Total Non- For UL

Month Certified for Paid Claims Claims QMB Both QMB Review

8/89 Non-QMB only Hospital crossover $560 560 Yes

Physician crossover 20 20 Yes

9/89 Dual QMB and Physician crossover 40 $40 No

Non-QMB

Initial UL $100

Prior months' claims 580

Revised UL 0

Determine the coverage groups to assign the review month claims.

Total

Claims Non-QMB Both QMB Unclassifiable

Physician crossover $ 12 $12

Medicare B buy-in for MN 27 $27

$ 39 0 $12 $27 0

Since the claims that can be identified as covered under the non-QMB group are eligible for payment because the UL was met with prior months' claims, determine the dollar amount of the eligibility error as the amount of the claims that can be covered only under the ineligible QMB plus the unclassifiable claims. Change the final eligibility status to eligible with ineligible services.

QMB only claims $ 27

Unclassifiable claims +0

27 eligibility error amount

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11-93 REVIEW PROCESS 7350

7350. FEDERAL MONITORING

To ensure that State MEQC systems are operating in accordance with Federal requirements and to assist each State agency in fully utilizing its MEQC system, Federal staff conducts ongoing appraisals of State operations. The Federal appraisal consists of:

o Management reviews of the administrative and operational aspects of the system on an as-needed basis;

o Ongoing monitoring of State activities in sampling, review, and corrective action; and

o Re-review of a subsample of State MEQC case reviews.

If Federal re-review determines that State case reviews have not been completed appropriately, HCFA may:

o Return an inappropriately dropped case(s) for full review;

o Complete an inappropriately dropped case(s) by Federal resources at State expense;

o Return a case(s) not containing required income and eligibility verification information and/or verification to request and verify appropriate information; or

o Obtain and verify required income and eligibility verification information by Federal resources at State expense.

HCFA conducts Federal re-reviews in compliance with the provisions of this manual and the Regional Office Manual.

If any of these or other Federal monitoring activities reveal that a State has failed to cooperate in completing a valid MEQC sample or individual reviews in a timely and appropriate fashion, HCFA establishes payment error rates based on:

o A special sample or audit;

o The Federal subsample; or

o Other arrangements as the HCFA Administrator may prescribe.

In addition, Federal MEQC staff assists HCFA by identifying State policy which conflicts with the approved State plan and State plan material that may have been incorrectly approved by the RO.

Section 7206 provides the appropriate instructions for reviewing all cases against the approved State plan. Federal MEQC brings matters of apparent conflict between State plans, State policy, and Federal regulation to the attention of the Medicaid policy staff for interpretation.

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7350 (Cont.) REVIEW PROCESS 11-93

Whenever differences exist between you and Federal review findings for MEQC cases which are federally re-reviewed, you are notified by a Federal difference letter. You may agree with the Federal findings or state your reasons for not agreeing, and may request a conference. However, you must respond to all Federal differences in writing, whether you agree within 28 days of the date of the difference letter. If you disagree with Federal findings, you must provide all documentation to substantiate your position within 28 calendar days from the date of the difference letter. The 28-day difference response period may be shortened if determined to be necessary by the RO with CO concurrence. This shortened response period must not be less than 10 working days. You may also request a difference conference to discuss the case. If, after reviewing arguments, HCFA maintains the Federal finding to be correct, you may appeal the case to the HCFA Regional Administrator (RA). The final decision concerning the difference is made by the HCFA RA. This decision is to be reflected in your MEQC statistical reports.

7355. RECORD MAINTENANCE

For purposes of Federal re-review and audit of State MEQC programs, you must maintain your official MEQC records to permit their ready access and use. Official MEQC records consist of documents which support your actions in the following areas:

o The case selection process, including but not limited to the data and/or working papers used to determine each month's sample frame, interval determination, and case selection method and the sample list;

o The case review process, including but not limited to Forms HCFA 301 and HCFA 316 and supporting documents, including Federal difference letters for all completed and dropped reviews. You must maintain copies of paid claims or histories for sample cases with your MEQC records; and

o The reporting process, including but not limited to all final 6-month MEQC reports.

Maintain official MEQC records for a period of 3 years following the submission of the final 6-month report. Retain the records beyond the 3-year period if audit findings have not been resolved or if additional action may be necessary.

You must mail to HHS staff all records as requested within 10 working days of receipt of the request unless HCFA has approved an additional 3 working days as needed.

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