ABD Medicaid Supervisory Review
Form 965
Instructions

Check the following prior to completing the supervisory review:

- Clearing House
- Alerts
- Notice History, as appropriate

Top Section of Form 965

- Check 1st Level Review if this is an initial review for this review period. Check 2nd Level Review if the 1st level review is being reviewed by another entity (Program Specialist, Economic Support Administrator, etc.).
- In the County field, enter the county name where the case and the MES worker reside.
- In the Worker's Name field, enter the name of the MES worker whose case is being reviewed and the worker's caseload number under CL #.
- In the Month(s) Under Review field, enter the month(s) in which the action was taken.
- In the Case Name field, enter the Head of Household's name or the A/R's name if a non-recipient is listed as the Head of Household. Enter the AU Number(s) of the AU(s) under review.
- In the COA(s) field, enter the class(es) of assistance under review.
- In the Type of Action field, enter either approval, denial, AMN spend-down authorization, review, special review or closure.
- In the Date of Action field, enter the date the worker completed the action on the case.
- If a related Food Stamp or TANF case exists, enter the related AU number(s) in the Other Programs Related Case Number(s) field.

Supervisory Review Section of Form 965

Decide if the worker has correctly addressed each element of the eligibility determination, patient liability/cost share budget, AMN FDL and BAD, notice requirements, case record organization and all procedural requirements, etc. If the reviewer cannot determine whether the element or information is correct, then the MES has not properly documented the AU. Mark the element as incorrect, even if the error does not result in an ineligible AU. There is no tolerance for incorrect PL/CS or AMN FDL/BAD. If the PL/CS amount or FDL/BAD is not exactly as it should be, indicate the error in the screen where the incorrect entry was made resulting in the error and also on the MAFI screen. Indicate your findings in the columns labeled C, I, or N/A.

- C – Correct means the worker correctly addressed that element.
- I - Incorrect means the worker incorrectly or insufficiently addressed that element.
- N/A –means not applicable for this COA or circumstance. (For example, PLAW screen is not applicable for L01 AU.) For Specials only, use N/A for errors attributable to another worker.

Base this decision on the following:

- Whether the data elements are entered correctly on the SUCCESS screens.
- Whether Documentation Standards have been followed on each screen.
- Whether the worker has adequately verified all points of eligibility needing verification.
- Whether the worker has adequately documented why verification was not requested on items deemed not questionable by the worker. If client statement (CS) is the verification, no further documentation is required.
- Whether the worker has correctly applied policy on all special considerations and all points of eligibility.
- Whether the worker has correctly followed all required procedures.
- Whether the worker correctly took action on information known to DFCS, including information in a related case, in Clearing House or in Alerts.
- Whether the worker made an unforeseen error that must be corrected. This error may be mathematical, system processing and/or keying. The error may have been caused by circumstances beyond the control of the worker, the judgment of the worker (not negligence or a mistake) and/or a procedural or administrative mistake that does not affect eligibility.

The Review Elements section closely follows the flow of the SUCCESS screens. The section is divided into major headings by the use of alphabet. Under each alphabet are sub-headings. The following is an explanation of how to interpret the individual elements, which may not be self-explanatory:

- The individual alphabet rows are used to indicate if all **data elements** are entered correctly on the SUCCESS screen and match the members' circumstances. It also indicates if items are found to be missing or incorrect other than those indicated beneath each alphabet. If the data element is applicable to the COA under review, then mark the element as C or I. Certain elements should always be correct/incorrect such as Case Record, UINC – Documentation Standards, RES1 – Documentation Standards, etc. N/A, C, or I should be used on the Documentation Standards row if the SUCCESS screen in question is required for that particular COA. However, the other elements within an alphabet may be N/A, if appropriate. For example, on the INST screen, if the case is L01 (NH), then the data elements "PL Inc Amt" and "KB Cost Effective" elements may be N/A. Explain in the comments section any errors indicated on the alphabet line.

ABD Medicaid Supervisory Review
(cont.)

- A. Case Record – Is the case record organized according to Section 2760? For applications, is a signed application in the CR? For reviews, is the review document in the CR or documentation of the source of the review if done by phone or in person?
- B. NARR – Reason for action taken should indicate if the action taken was the result of review, application, special, etc. Is the HIPPA form current and in file or is there documentation that one was sent to all appropriate parties?
- D. AREP – Are all appropriate entities entered such as PR, Hospice agency, CCSP case manager, QIT Trustee, etc. and appropriately coded as R1 (if the Medicaid card is to go to the A/R)?
- E. STAT – Is the COA the most advantageous one for the A/R? Was a CMD done, if appropriate? If the reason for denial/closure is a 500 level reason, is it documented appropriately? Are the Financial Responsibility codes entered appropriately for the COA and circumstances of the AU?
- F. DEM1 – Is the date of birth correctly entered and verified; is the age established? Is the SSI Status documented if other than R or N? Have dates been documented as to when the disability request was sent to and received from SMEU or DAS?
- H. ALAS – Do EMA dates entered reflect those on the Form 526?
- I. INST – Are PL/CS deductions, such as IMEs, diversion, protection of income, Medicare premium, etc, correct? Are the Payment Authorization and Termination dates correct? Are Slot Dates for waivered COAs correct? Are the Katie Beckett Cost Effectiveness and other related forms in the case record?
- O. DEAL – This screen is only applicable if there is an ineligible spouse in the case and allocation is needed for children. If there is no ineligible spouse, then all elements are N/A.
- P. UINC – Was Application for Other Benefits addressed (N/A for Q Track? Were all Deductions entered correctly?
- Q. PLAW – Has the worker explained how s/he determined the specific Public Law COA?
- S. MISC – Was 10, 45 or 60 day SOP met for AU(s) under review? If not, was the delay reason entered and documented on the Remarks screen (C, I, or N/A). QMB Override, N/A for all but QMB COA.
- U. SDME/SPAU – Was the screen coded correctly?
- V. Notice Requirements – Were the correct notices generated? Was notice or timely notice waived inappropriately? Should a manual notice have been completed, such as a Form 400, etc? Are the manual notices correct?

In the Comments section, indicate how the worker has failed to correctly address the element.

<u>Accuracy Review Findings Section of Form 965</u>

In the left hand block, enter the following:

ABD Medicaid Supervisory Review
(cont.)

- Total C – Enter the total elements checked as correct, including the Alphabet rows.
- Total I – Enter the total elements checked as incorrect, including the Alphabet rows.
- Total N/A – Enter the total elements checked as not applicable in this situation, including the Alphabet rows.
- Total All – The total of C, I and N/A should be 79.

In the center block, enter a check next to any that apply, as follows:

- Ineligible/ineligible member – Was the AU approved when it was actually ineligible? Was a member of the household approved who was actually ineligible? Circle which it was.
- Invalid Denial/Termination – Was the AU incorrectly denied or closed? Circle which it was.
- Invalid Approval for Month(s) – Indicate any specific month(s) which were approved in error.
- Incorrect COA – Was QMB approved if the A/R can be dually eligible? Was the A/R approved for an incorrect or less advantageous COA? Indicate the correct or more advantageous COA to the right.

In the block on the right, indicate if there were any errors resulting in incorrect PL/CS or incorrect AMN spenddown amounts, begin authorization date, or first day liabilities.

Under # Correct Elements Divided by Total # Elements Addressed, compute the accuracy rate on the supervisory review of this AU. By using the figures indicated in the left block, divide the number of correct elements by the sum of the incorrect and correct elements. For example, if the AU contained 60 correct elements and 12 incorrect elements, you would divide 60 by 72 for an accuracy rate of .833333 or 83%. Complete the Goal % according to what is the most current Medicaid Goal Accuracy Rate set by the State Office.

In Action to be Taken, indicate any corrections, clarifications, documentations, etc. which must be completed by the worker and a reasonable due date for completion. Follow up on the due date to assure that the actions have been completed.

The supervisor or second level reviewer should sign and date the form upon completion of the review. The caseworker should sign and date the form after the supervisor has reviewed the findings with the worker. The worker may also make any comments s/he deems appropriate.

Complete the form in duplicate. File a copy in the case record which was under review. Maintain the second copy in a central file or in the worker's productivity file. Document on NARR the date that the case was reviewed, the reviewer name and the accuracy rate findings. Also indicate either, "No corrections needed" or "Corrections due by MM/DD/YY".