APPENDIX H – MEDICAID ADMINISTRATIVE REVIEWS OVERVIEW

POLICY STATEMENT	Medicaid records are subject to review by the Department of Community Health/Division of Medical Assistance/Quality Control, the Georgia Office of Audits and by supervisory and administrative staff of the Georgia Department of Human Resources/Division of Family and Children Services.
BASIC CONSIDERATIONS	
DCH/DMA QC	Quality Control Reviewers from the DCH/DMA read randomly selected cases for accuracy. County Staff will receive a Quality Control Communicator discussing the findings. County Staff are expected to take appropriate action in a timely manner as specified in the Communicator.
QC Rebuttals	Counties wishing to rebut QC findings should send a request for rebuttal to: Jwalker@dch.ga.gov. In the request, counties should include the following: • Case name • AU ID number • Review number • County name, contact person, and phone number • Reason for rebuttal
ASO/PERM Reviews	Administrative Services Organization (ASO) reviews are conducted on a monthly basis. DCH contracts with an independent vendor (Maximus) to review 850 case records per month. This is a State level review and is **not** a measurement of benefit or claim errors, but is used to measure the overall quality of case work conducted by DFCS Medicaid case managers. Payment Error Rate Measurement (PERM) is a Federal review overseen by the Center for Medicare and Medicaid Services (CMS), the Federal Medicaid oversight agency, which measures actual benefit and claim errors. Each state is reviewed once every four years, with the entire country being reviewed in a given four year period. Georgia was among the first states to undergo this process **beginning** with the January 2007 sample and ending with the September 2007 sample.

BASIC CONSIDERATIONS (cont.)

Cases for ASO reviews are requested for the month prior (the sample month) via fax sent to counties as indicated by the RESCO field in SUCCESS. A spreadsheet listing all the cases requested for a sample month, screened in SUCCESS for current county location, is also sent out to Regional Management. The county DFCS office for which the case is listed in SUCCESS as currently residing is responsible for returning the case record to DCH.

Requests for ASO Records

Counties are faxed requests by the DCH reviewers for case records. The faxes from DCH are based on where the case was located the month under review and listed in the RESCO field, which may or may not reflect the current location of the case record in SUCCESS.

The State Medicaid Policy Unit receives a spreadsheet from DCH with all the case requests which is then screened in SUCCESS for current location, COA and status of the case. It is sorted by Region and county and includes the Load ID from STAT and sent out to the Regional Medicaid Field Program Specialists.

Included on the spreadsheet are additional columns: to track that the case record has been sent in (Mailed); Exception, for if the case is reported with an exception; the exception type, if applicable; and the date of the response to DCH. The Medicaid FPS for each Region should track this information for the Region.

The county that **currently** has the Case Record is responsible for sending it to DCH, whether that county receives a fax request for the CR or not.

A case that is reviewed and found correct will be returned to the county which currently has the case in SUCCESS. **The county which completed the action under review will get credit for a correct case.**

Records for ASO should be returned to DCH within 14 days of request. Cases should be checked prior to being sent in to ensure to the current volume is being sent; that documentation is complete; and that it has all received verification filed in it. Permanent verification should be pulled forward from any earlier volumes to current volume. If an action was completed in the

review month by the Call Center which required verification, verification should be requested immediately from the Call Center and filed in the case record before forwarding to DCH.

Counties should not wait to act on the records requests. Case records not received by the fourth working day prior to the end of the month following the month the initial request was received will not be read.

Records should be sent to:

Johnnie Walker (jwalker@dch.ga.gov)
Quality Control Program Director
Department of Community Health
P.O. Box 38420
Atlanta, GA 30334

Responses to ASO Reviews

Correct cases require no response. Please do **not** to respond when a communicator indicates the case was correct.

Exception Responses are to be sent via email within 15 calendar days to the DCH reviewer and copied to the Medicaid Unit Manager and designee. The response must include:

- Name of member reviewed
- Review #
- Type of Review (ASO, PERM or QC) – a "Maximus" review is an ASO. PERM should be indicated at the top of the communicator.
- DCH reviewer
- Name/County/Position of the responder
- Include on the subject line: "ASO Exception Response: Member Name – Review # - County Name".

(Note: Counties may use the ASO/PERM Response form in Appendix F attached to an email to respond to ASO and PERM errors. DCH email addresses are formatted first initial and last name followed by "@dch.ga.gov". E.g. jdoe@dch.ga.gov.)

Rebuttals

Rebuttals of ASO exceptions or PERM errors should be submitted as soon as possible but no later than 15 Calendar days from receipt of the error.

Rebuttals must be routed through the Region Medicaid FPS who should review to ensure the rebuttal is appropriate and correctly address policy.

- **Send** to Johnnie Walker at DCH (jwalker@dch.ga.gov) and CC the Medicaid Unit manager and designee.
- Include on the subject line**: "ASO** Rebuttal: Member Name – Review # - County Name".
- Ensure that any copies of verification sent or faxed with the rebuttal are legible.

Errors/Exceptions on Transferred Cases

For cases that were transferred to another county after the sample month and are determined to have an error in sample month:

- The case record with the error summary will be returned to the county that sent in the record.
- The county should contact the Regional FPS indicating an exception or error was found on a transferred in case., who should contact the county that completed the action found to be an exception or in error (or the FPS for the Region if the county is in another Region) informing them of the exception/error.
- **The county which completed the action under review is responsible for making any correction and will be assigned the exception/error.**
- If necessary, the case should be transferred back to the responsible county to complete any necessary changes or corrections.
- After appropriate corrections and responses have been made, the case should be transferred back to the county of residence (if it had been transferred back to the original county) and the case record mailed back to that county.
- The FPS should inform the State Medicaid Unit when this occurs.

Department of Audits and Accounts

The Georgia Department of Audits and Accounts will conduct yearly reviews on a randomly selected sample of cases. Auditors reviewing cases are looking for the following:

- Application form
- Form 297A, if applicable
- Form 297M, if applicable
- Verification/Documentation of Citizenship/Alien Status
- Verification/Documentation of Georgia Residency
- Verification/Documentation of Income
- Verification/Documentation of Resources
- Child Support Enforcement forms, if applicable
- Third Party Liability Documentation/Form 285, if applicable
- CCSP and other Communicators, if applicable
- Medical bills for spend-down budgets

- Timely reviews and review forms

Findings from this review are shared with the Division of Family and Children Services and are generally not case specific.

County/Regional Reviews

County supervisors, administrative staff and Medicaid Program Specialists also review Medicaid records.

Each Medicaid supervisor should complete Medicaid Quality Checks on cases for members of his or her unit prior to being finalized in SUCCESS. The number of Quality Checks completed should be of a reasonable number, but should not exceed 5 checks per month per worker in the unit.

Medicaid Quality Check

The Medicaid Quality Check is a targeted review completed by a supervisor or other designated reviewer prior to the Medicaid case being completed in SUCCESS. The elements under review are based on error trends identified in the ASO or PERM review process. Elements for review can also be identified based on County or Regional needs. The Quality check is intended to be flexible and adaptive in order to reflect current needs and trends rather than identify issues or trends from three to six months in the past.

The objective of the Medicaid Quality Check is to ensure cases are determined correctly prior to finalization and that AUs are issued the Medicaid benefits for which they are entitled. Other objectives include:

- To identify error trends at various levels, from individual workers to statewide.
- To provide county and Regional departments with information necessary to request technical or training assistance from the State Office.
- To provide the State Office with information necessary to offer technical assistance to county departments and to develop quality improvement plans.

Targeted areas are read on a pass/returned basis. A case passes that has had all targeted areas of eligibility determined correctly in accordance with all relevant policy and procedures, including documentation standards. Cases which pass are those that can stand on their own in SUCCESS and the material in the case record without requiring additional explanation or documentation.

Quality Check Returns

A case is returned as part of the Medicaid Quality Check when

any element under review does not pass. There are no deficiencies. All targeted elements should be read even when an element does not pass.

There six general reasons for which a particular area may not pass a quality check. These are:

- Policy misapplied
- Incomplete documentation
- Failure to verify
- Incorrect coding (SUCCESS)
- Reported information disregarded or not applied
- Computational error

These reasons should be annotated on the Quality Check form and compiled and reported as part of the county's monthly report of Case Review results.

A case that does not pass all targeted areas is subject to "return" and must be sent back to the case manager for correction prior to finalization. The reviewer should give the "return" an appropriate time frame in which to be resubmitted and subjected to another Quality Check.

Cases should be submitted for Quality Checks in a timely fashion to ensure completion within the applicable Standard of Promptness (SOP). Supervisors should select the cases for Quality Check and should NOT permit staff to select the cases to be checked. The supervisor should select a variety of case actions and COAs for review.

General guidelines for the current elements targeted in the Medicaid Quality check may be found in the Medicaid Quality Check Guidelines document.

Administrative Reviews

County Program Directors (CPD), Economic Support Administrators (ESA) or Medicaid Program Specialists, in the absence of a CPD/ESA, should complete second level reviews. The sample size for second level reviews should be 5% of the total number of Quality Checks read per supervisor and/or unit (not to exceed 3 per unit or supervisor) monthly. Cases should be selected from all Quality Checks completed in the previous month. In counties with second level administrative positions, Program Specialists should review randomly selected second level reviews to ensure correctness and verify all required corrections were completed in a timely manner.

The objective of Administrative Reviews is to ensure that the Quality Check process is being followed correctly and that front line reviewers are accurately reviewing the cases.

An Administrative review finding is either correct or incorrect, there are no deficiencies. A correct case is one in which the front line reviewer correctly determined "pass" or "fail" on the Medicaid Quality Check.

REVENUE MAXIMIZATION READING REQUIREMENTS

For Children in Placement review requirements please refer to the CAR Selection Process Guide, Revenue Maximization Unit. All Medicaid specific elements are explained in the Family Medicaid Reading Guide, Revenue Maximization Unit. Both are found in Appendix H – Administrative Review.

For Children in Placement, the following definitions are used in case reading:

- Correct Case – Medicaid eligibility, COA, funding source and reimbursability are correctly determined and thoroughly documented in case record and SUCCESS.
- Deficient Case – Initial, review or change element insufficiently addressed in case record and/or SUCCESS documentation *and* all eligibility and reimbursability elements are correctly determined.
- Error Case – May be any of the following:
  - Incorrect eligibility and/or reimbursability determination
  - Eligible for and not receiving benefits.
  - Incorrect AFDC Relatedness criteria determination: financial need, deprivation, specified relative, living with/removal from, age
  - Ineligible for but receiving benefits
  - Denial or closure of a case that was actually eligible

ABD READING REQUIREMENT

Selection Criteria

Supervisors will select the cases to be read based on the activity completed in the month under review. This may be the previous or current month's case actions. Do NOT permit staff to select the cases to be read. The supervisor will select a variety of case actions and COAs for review. However, as needed, the Medicaid Unit and/or the Medicaid Program Specialist may indicate specific targeted policy issues, elements or COAs for review, which may override the usual selection criteria. The reading of a dually eligible case (full Medicaid and Q Track COA only) count

as one review, not two. However, two full Medicaid COAs count as two supervisory reviews.

There are two selection standards depending on whether the supervisor manages ABD/FS staff only or multiple programs. The number of cases selected will depend on the number of workers supervised as well as supervision being program specific or multi-program. If the supervisor is reading FS cases, it is permissible to include the related ABD case as part of the ABD reading requirement. However, not all ABD cases read should have a related FS case.

NOTE: Consult your Medicaid Program Specialist for reading requirements on specialized caseloads, such as intake only or QMB/AMN case loads only.

A supervisor of ABD and related FS staff only will read four times the number of workers s/he supervises, not to exceed 30 ABD cases per month. This does not necessarily mean four cases per worker. For example, for a new MES or a MES on a work plan, more than four cases each may need to be read per month. For every four cases reviewed, read two applications, one negative action (closure or denial, and one annual review or special.

A multi-program supervisor (covers ABD Medicaid and program(s) other than related FS) will read three times the number of MES staff supervised, not to exceed 25 ABD cases. This does not necessarily mean three cases per worker. For example, for a new MES or a MES on a work plan, more than three cases each may need to be read per month. For every three cases reviewed, two should be applications (one of which may be a denial) and one a special or annual review.

How To Read

Supervisor's review findings will be as of the moment the case is read. Do **NOT** withhold supervisory review findings to give the MES an opportunity to make corrections. The accuracy rate is based on the findings as of the initial supervisory review. Corrections are made after the accuracy rate is determined.

Applications: Read for all affected months, beginning with the earliest of the prior months (if any) through the ongoing benefit month.

Annual Reviews: Read only the month of the review for all data elements required for the COA. Errors which occurred in months other than the month read will be counted incorrect only if the error affects the month being read for the review/special.

Specials: A "Special" is any case action taken other than application, annual review or denial. Read the entire case. However, only consider elements in error that were the result of the action taken by the current worker when calculating the accuracy rate of the case. All errors must be corrected.

Denials: Read all screens applicable to the denial and the reason for the denial. This includes at a minimum: Case Record, NARR, ADDR, STAT, AREP, and Notice Requirements.
Refer to the instructions accompanying Form 965 and Form 974 for specifics on how to complete. It is important to strictly adhere to the guidelines to ensure statewide standards and fairness.

Online Review Site

ABD reviews should be completed using the ABD online review site. While the supervisor may review a case using the Form 974, Supervisory Review Summary Sheet, and keep a copy in a central file, it is not necessary to submit a copy to the State Office. Findings on each case reviewed should be reported via the ABD Medicaid Supervisory Review Database. These results are automatically reported to the State Office Data Analysis and Reporting section, which completes monthly reports on a county, regional and state level.