APPENDIX H – MEDICAID ADMINISTRATIVE REVIEWS OVERVIEW

POLICY STATEMENT	Medicaid records are subject to review by the Department of Community Health/Quality Control, the Georgia Office of Audits, DCH PERM Contractor, and by supervisory and administrative staff of the Georgia Department of Human Services/Division of Family and Children Services.
BASIC CONSIDERATIONS	
ME QC Reviews	The MEQC program is a statutory requirement under Section 1903(u) of the Social Security Act. It requires States to annually provide an estimate of improper payments in Medicaid based on eligibility reviews of States' recipients. MEQC is directed at improving the quality of State eligibility determinations. In Georgia, the MEQC process is managed by DCH and reviews are conducted on a monthly basis. DCH QC reviews 400 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.
LIM Negative Reviews	ME QC completes 150 desk reviews a month on LIM cases that are closed. 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: Wemerritt@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
PERM Reviews	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 improper payments in Medicaid and the Children's Health Insurance Program (CHIP) based on reviews of States' eligibility determinations of applicants and recipients. Each state is reviewed once every three years, with the entire country being reviewed in a given three year period. The next PERM sample period for Georgia will start October 2012.

Requests for Case Records

Cases for ME QC reviews are requested for the identified sample month on or around the 5th of each month. This request is sent to the DFCS Medicaid policy unit and the cases are screened in SUCCESS for their current location, COA and status of the case. The results are entered in an Excel spreadsheet and sorted by Region and county and includes the Load ID from STAT.

Each Region is required to submit to the State Office Medicaid Unit a Case Record Request that includes:

- the name and contact information of a primary individual responsible in the Region for disseminating the record request to the counties in the Region
- the name and contact information of a back-up individual in case the request comes when the primary individual is away from the office
- the process the Region will use to disseminate the request to the counties in the Region, including time frames
- the process the Region will use to validate that case records have been mailed timely

Case records requests, including MEQC record requests, are sent to the primary and secondary contacts identified in the Region Case Record Request plan and to the Regional Management and Medicaid Field Program Specialists along with the due date specified by DCH. Case records are due to DCH by noon on the due date.

The county DFCS office for which the case is listed in SUCCESS as currently residing is responsible for returning the case record to DCH.

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.

The record should contain a cover sheet on where to return the record after the review is completed by DCH. Case records for different sample months should NOT be sent in the same package.

Five business days prior to the date due to DCH MEQC, each Region will report to the DFCS OFI Medicaid Unit that the case records have been sent to MEQC or why they have not been using the original spreadsheet sent for the Request. Each record will be annotated sent or not sent, with an explanation for why

Request for Case Records (cont.)

any record was not sent.

For case records that cannot be located, the Region must:

- provide an explanation of the efforts taken to locate the record
- steps taken to ensure the legitimacy of the original actions taken; and
- for active cases where the record cannot be located within 30 days, conduct a complete renewal of all points of eligibility, including obtaining any required verification (including any needed permanent verification) no later than the month following the month the record was requested

If the Medicaid unit does not hear from a Region by the close of business on the fifth business day prior to the due date of the records, the Regional Manager will be called the following business day requesting an explanation.

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.**

RSM Project MEQC/PERM Procedures

When case records are requested for ME QC/PERM review that are still with the RSM Project –

- the RSM Supervisor whose worker has the case will review the case prior to sending it in for review.
- If previous SUCCESS coding/documentation of citizenship/ID verification was used to approve the case, the RSM Supervisor will request of the originating county via email copies of the applicable verification be faxed directly to him or her.
- The email will have in the subject line "ME QC/PERM Verification Request, due ___(date) .
- A copy of the email will go to the RSM Project Manager, the RSM Project Director, and the Medicaid Field Program Specialist for the Region.
- If there is no response after 5 days, the RSM Project supervisor will file a printed copy of the e-mail in the case record to show the documentation was requested from the original county.

The ME QC Citizenship/ID exception for such cases will be charged against the original county.

Mailing Addresses

MEQC Reviews

Records for the ME QC review should be sent to:

Wesley Merritt (wemerritt@dch.ga.gov)
Medicaid Quality Control Program Director
Department of Community Health
P.O. Box 1984
Atlanta, GA 30301

If using UPS as the carrier, send to:

Wesley Merritt (wemerritt@dch.ga.gov)
Medicaid Quality Control Program Director
Department of Community Health
2 Peachtree St., NW
39th Floor
Atlanta, GA 30303

PERM Reviews

PERM case record requests should be returned to:
PERM Records Clerk
Medicaid Quality Control Program
Department of Community Health
P.O. Box1984
Atlanta, GA 30301

If you are sending by **UPS**, send to:

PERM Records Clerk
Medicaid Quality Control
Department of Community Health
2 Peachtree St., NW
39th Floor
Atlanta, GA 30303

Please attach a print out of the spreadsheet listing the case record(s) being returned with the case(s) highlighted.

PERM/ME QC Review Responses

Responses requested are to be sent **via email** within 15 calendar days to the DCH reviewer and copied to the Medicaid Unit Manager and designee. No hard copy response is required. The response must include:

- Name of member reviewed
- Review #
- Type of Review (ME QC, PERM or LIM – this should be indicated at the top of the communicator)
- DCH reviewer
- Name/County/Position of the responder
- Include on the subject line: "ME QC (or PERM or LIM) Response: Member Name – Review # - County Name".

(Note: Counties may use the ME QC/PERM Response form in Appendix F attached to an email to respond to ME QC, PERM and LIM 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 ME QC, PERM or LIM 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 Wesley Merritt at DCH (wemerritt@dch.ga.gov) and CC the Medicaid Unit manager and designee.
- Include on the subject line**: "ME QC (or PERM or LIM)** 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/Immigration Status
- Verification/Documentation of Georgia Residency
- Verification/Documentation of Income
- Verification/Documentation of Resources
- Child Support 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.

State Medicaid Single Audit

A yearly single audit is conducted for DCH by the firm of Metcalf Davis, Mauldin & Jenkins. Included in the audit is a review of DFCS eligibility processes. Five counties are chosen for review with a total sample of 60 case records. This review is conducted July through August of each year. Findings from this review are shared with DCH and 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 ME QC, LIM 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.