MA-2900 RECIPIENT FRAUD AND ABUSE POLICY AND PROCEDURES
REVISED 07/01/08 - CHANGE NO. 16-08

I. PURPOSE

This section provides procedures to comply with Federal and State Medicaid requirements regarding potential fraud and misrepresentation that results in medical assistance overpayments. Although methods for handling cases may vary between county departments of social services, disposition and reporting of these cases must be consistent.

II. LEGAL RESPONSIBILITY AND REFERENCES

Both the state and the county departments of social services have a legal obligation to assure proper administration of public funds and an obligation to take necessary legal steps in cases of fraud or misrepresentation. This obligation rests on the efficiency, thoroughness and integrity of the processes by which initial and continuing eligibility are determined.

A. **Social Security Act, Title XIX, Section 1909** and the implementing Federal Regulations 42 CFR Part 455 entitled "Program Integrity" sets forth the requirements for the control of fraud and abuse in the Medicaid program by the state Medicaid agency, the Division of Medical Assistance (DMA).

B. **North Carolina Administrative Code 10 NCAC 22F .0103** sets forth the procedures to prevent, detect, investigate, report, identify and collect all improper payments, and to impose administrative measures for the control of fraud, abuse and over-utilization practices by providers and clients.

C. **North Carolina Administrative Code 10 NCAC 22.0700** contains procedures established by DMA regarding client fraud and abuse. This Section contains requirements for the prevention, detection, investigation, referral, prosecution, and recoupment of overpayments, and for the reporting of fraud, abuse and over-utilization. These procedures are supervised by DMA and administered by each county dss. Also included are the procedures for the equitable distribution of overpayments collected in cases involving overpayments in more than one assistance program.

III. NORTH CAROLINA GENERAL STATUTES

The following are General Statutes Applicable to Medical Assistance Fraud/Abuse:

A. North Carolina General Statue 108A-64 entitled "Medical Assistance Recipient Fraud" contains the penalties related to fraud in the Medicaid program. It states that it shall be unlawful for any person to knowingly and willfully and with intent to defraud make or cause to be made a false statement or representation of a material fact in an application for assistance under this part, or intended for use in determining entitlement to such assistance.

It shall be unlawful for any applicant, client or person acting on behalf of such applicant or client to knowingly and willfully and with intent to defraud, conceal or fail to disclose any condition, fact or event affecting such applicant's or client's initial or continued entitlement to receive assistance under this part.

It is unlawful for any person knowingly, willingly, and with intent to defraud, to obtain or attempt to obtain, or to assist, aid, or abet another person, either directly or indirectly, to obtain money, services, or any other thing of value to which the person is not entitled as a client under this Part, or otherwise to deliberately misuse a Medicaid identification card. This misuse includes the sale, alteration, or lending of the Medicaid identification card to others for services and the use of the card by someone other than the client to receive or attempt to receive Medicaid program coverage for services rendered to that individual.

Proof of intent to defraud does not require proof of intent to defraud any particular person. A person who violates a provision of this section shall be guilty of a Class I felony if the value of the assistance wrongfully obtained is more than four hundred dollars ($400.00).

A person who violates a provision of this section shall be guilty of a Class I misdemeanor if the value of the assistance wrongfully obtained is four hundred dollars ($400.00) or less.

For the purposes of this section the word "person" includes any natural person, association, consortium, corporation, body politic, partnership, or the group, entity or organization.

B. **NCGS 14-100. Obtaining property by false pretenses** can be used when prosecuting fraud cases in all social services programs. It should be noted that cases prosecuted under this statute are felonies regardless of the amount involved.

(III.B.)

If any person shall knowingly and designedly by means of any kind of false pretense whatsoever, whether the false pretenses of a past or subsisting fact or of a future fulfillment or event, obtains or attempts to obtain from any person within this state any money, goods, property, services, chose in action, or any thing of value with intent to cheat or defraud any person of such money, goods property, services, chose in action or other thing of value, such person shall be guilty of a felony.

Provided, that if, on the trial of anyone indicted for such crime, it shall be provided that he obtained the property in such manner as to amount to larceny or embezzlement, the jury shall have submitted to them such other felony proved; and no person tried for such felony shall be liable to be afterwards prosecuted for larceny or embezzlement upon the same facts:

Provided further that it shall be sufficient in any indictment for obtaining or attempting to obtain any such money, goods, property, services, chose in action, or other thing of value by false pretenses to allege that the party accused did the act with intent to defraud, without alleging an intent to defraud any particular person, and without alleging an intent to defraud any particular person, and without alleging any ownership of the money, goods, property, services, chose in action or other thing of value; and upon the trial of any such indictment, it shall not be necessary to prove either an intent to defraud any particular person or that the person to whom the false pretense was made was the person defrauded, but it shall be sufficient to allege and prove that the party accused made the false pretense charged with an intent to defraud. If the value of the money, goods, property, services, chose in action, or other thing of value is one hundred thousand dollars ($100,000) or more, a violation of this section is a Class C felony. If the value of the money, goods, property, services, chose in action, or other thing of value is less than one hundred thousand dollars ($100,000), a violation of this section is a Class H felony.

Evidence of non-fulfillment of a contract obligation standing alone shall not establish the essential element of intent to defraud.

C. Statutes of Limitations

When referring cases for prosecution in either criminal or civil court, the county dss must be aware of the statutes of limitations that apply to these cases. These statutes affect the amount of overpayment presented in court and the specific charges brought against the client.

1. **Criminal Statute - NCGS 15-1** is the statute of limitations for criminal misdemeanors. This statute allows prosecution action of misdemeanors to be taken no later than two years after the fraudulent act occurred. A misdemeanor under the current NCGS 108A-64, are cases involving $400.00 or less.

(III.C.)

2. There is no statute of limitations for felonies, that is, cases involving over $400.00**.** However, prior to July 1, 1977, all fraud cases against the Medical Assistance program were misdemeanors. Therefore, for cases in which a fraudulent act was committed prior to July 1, 1977, the criminal statute of limitations has expired regardless of the amount of the overpayment for that act. The North Carolina Attorney General's Office has rendered the opinion that an act is determined as the initial false statement, misrepresentation, and/or omission of fact, running to the next recertification or contact with the client at which time false statement, misrepresentation, and/or omission of fact could have been corrected. Each certification period or period between contacts, thereafter, during which time the recertification, misrepresentation, and/or omission of fact is perpetuated, is considered a separate offense.

   Therefore, in cases involving overpayments made prior to July 1, 1977, if a recertification period began prior to July 1, 1977, and continued after that date, that specific recertification period would not be prosecutable in criminal court regardless of the amount as the statute of limitations has expired.

3. **Civil Statute NCGS 1-52** The civil statute of limitations runs for three years from the date the act is discovered or should have been discovered through the exercise of reasonable care.

   NOTE: If the client has signed a repayment agreement containing the word "Seal" next to the signature, the civil statute of limitations for enforcement of collection is ten years from the date the document was signed. However, the client must circle the word “Seal.” The investigator should contact the county attorney for further information regarding this point.

D. Statutes Governing Confidentiality

1. **General Statute 108A-80, 143B-153** each county dss is responsible for developing a confidentiality policy that is consistent with state law. (See MA-300) According to the Attorney General's office, investigators are bound by the same rules of confidentiality as are other staff members of the county dss. Therefore, it is necessary for each investigator to have discussed these statutes with their county or agency legal counsel.

2. **Section 1902(a)(7) of the Social Security Act** requires a State plan that provides safeguards to restrict the use or disclosure of information concerning clients to purposes directly connected with the administration of the plan. This subpart specifies State plan requirements, the type of information to be safeguarded, the conditions for the release of safeguarded information and restrictions of the distribution of other information.

(III.D.)

3. **Section 1137, 4359.40 ff of the Act**, which requires agencies to exchange information in order to verify income and eligibility of clients, also requires State agencies to have adequate safeguards to assure that:

   a. Information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information, and information received under section 6103(l) of the Internal Revenue Code of 1954 is exchanged only with agencies authorized to receive that information under that section of the Code, and

   b. The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

   Source: As re-designated, 44 FR 17926 (March 23, 1979) and amended at 51 FR 7178 (February 28, 1986, effective May 29, 1986)

4. **42 CFR 431.301** State Plan Requirements

   A State Plan must provide, under a State statute that imposes legal sanctions, safeguards meeting the requirements of this subpart that restrict the use or disclosure of information concerning clients to purposes directly connected with the administration of the plan.

   Source: As re-designated, 44 FR 17926 (March 23, 1979)

5. **42 CFR 431.302** Purposes directly related to State Plan administration include:

   a. Establishing eligibility

   b. Determining the amount of medical assistance

   c. Providing services for clients

   d. Conducting or assisting an investigation, prosecution or civil or criminal proceeding related to the administration of the plan.

   Source: As re-designated, 44 FR 17926 (March 23, 1979)

6. **42 CFR 431.303** State Authority for Safeguarding Information

   The Medicaid agency must have authority to implement and enforce the provisions specified in this subpart for safeguarding information about clients.
   Source: As re-designated, 44 FR 17926 (March 23, 1979)

(III.D.)

7. **42 CFR 431.304** Publicizing Safeguarding Requirements

The agency must publicize provisions governing the confidential nature of information about clients, including legal sanctions imposed for improper disclosure and use.

The agency must provide copies of these provisions to clients and to other persons and agencies to which information is disclosed.

Source: As re-designated, 44 FR 17926 (March 23, 1979)

8. **42 CFR 431.305** Types of Information to Be Safeguarded

The agency must have criteria that govern the types of information about clients that are safeguarded. This information must include at least:

a. Names and addresses

b. Medical services provided

c. Social and economic conditions or circumstances

d. Agency evaluation of personal information

e. Any information received for verifying income eligibility and amount of medical assistance payments (see 435.940 ff). Income information received from SSA or IRS must be safeguarded according to the requirements of the agency that furnished the data.

9. **Legal Restrictions**

The Privacy Act permits an individual to have some control over the accuracy and disclosures of records maintained by Federal Agencies. However the Privacy Act of 1947 (P.L. 93-579) Section 552b (7) allows a fraud investigator to obtain information necessary to conduct a civil or criminal investigation.

The client and legal counsel have the legal right to view and have a copy of the information in the eligibility or services record at anytime with the exception of:

a. Information that the county dss is required to keep confidential by state or federal statute or regulation.

(III.D.9.)

b. Confidential information originating from another source.

c. Information that would breach another third party's right to confidentiality. (Reference: 10 NCAC 24B .0306 and 20 NCAC.32S .0306)

d. Investigative records.

IV. FRAUD VS. MISREPRESENTATION

A. General

Although fraud is a question for the courts to determine, the county dss must determine whether there is a basis for belief that fraud may have been committed. In making this decision, intent and the mental competency of the individual must be considered. Also, a clear distinction, based on verified facts, must be made between misrepresentation with intent to defraud and misstatements due to the misunderstanding of eligibility requirements or of the responsibility for providing the county dss with information. It is also important to distinguish between intent to defraud and omission, neglect, or error by the county dss in helping a client to understand his responsibilities and in securing and recording pertinent information.

B. Fraud vs. Misrepresentation

1. Fraud

By law, fraud is a crime against society that can only be determined in a criminal court. It is the willful and intentional act that creates the crime, rather than the resulting overpayment.

a. For Medicaid purposes, the following definition of "client" applies throughout this policy:

Client – The client, parents and/or financially responsible adults of a minor child, legal spouse of a client, or a representative acting in behalf of a client. They may all be debtors except a minor child. All debtors are jointly and separately liable for the medical assistance overpayment.

b. A client is suspected of fraud when the client willfully and knowingly and with the intent to deceive:

(1) Makes a false statement or misrepresentation, or

(2) Fails to disclose a material fact, or

(3) Does not report changes in income or other eligibility factors that affect the benefit, and

(4) As a result, obtains, attempts to obtain or continues to receive assistance.

2. Misrepresentation

Misrepresentation causes monetary loss as a result of a client's action or inaction. Misrepresentation can be intentional or unintentional.

a. **Intentional misrepresentation** - The client gives incorrect or misleading information in response to either oral or written questions. The information is provided with the knowledge that it is incorrect, misleading or incomplete. **This is suspected fraud until decided by a court of law**. If the courts so decide, the claim should be changed in the Enterprise Program Integrity Control System, (EPICS) to an Intentional Program Violation (IPV). Document the change in EPICS Notepad.

b. **Unintentional misrepresentation** - There is no proof that the client acted willfully and intentionally to obtain more benefits than those to which he was entitled. The client gives incomplete, incorrect or misleading information because he does not understand the eligibility requirements or his responsibilities to provide the county dss with required information. This would be shown in EPICS as an Inadvertent Household Error (IHE).

3. Criteria for Fraud

To have a cause for action for fraud in public assistance cases, there must be proof of a statement made by the client, and the following conditions must be found with regard to such statement:

a. The statement is false, and

b. The client knows that the statement is false, or the client makes the statement recklessly and with knowledge of the truth or falsity of the statement, and

c. The statement is made by the client, with the intent that it will be relied on by the county dss, and that it will induce the county dss to authorize assistance to which the client is not entitled or to assistance greater than that to which the client is entitled, and

(IV.B.3.)

d. The county dss does in fact rely upon the statement given by the client, and awards assistance to which the client is not entitled or assistance greater than that to the client is entitled, and

e. The county dss has informed the client, of the law relating to fraud and appropriate information has been entered in the agency record, and

f. The client has signed a statement that all information given by the client and/or his representative pertaining to his eligibility is correct and true to the best of his knowledge.

V. PREVENTION

A. Interviewing

1. A key to fraud prevention is skillful interviewing during the initial application, at reviews and when changes in situation occur. Ask the client specific questions, evaluate his reaction and document the responses.

2. Prior to interviewing a client for a review, examine the case record. Take note of previous work history, income, prior reserve such as bank accounts, insurance policies, etc., and other eligibility factors.

3. The interview process involves two-way communication. Be specific and thorough in the questions asked. Phrase questions in a way the client will understand. Give the client a chance to respond in his own words. Listen carefully to the client's responses.

4. Follow these steps at interviews:

   a. Explain to the client his obligation to report all changes in situation within ten (10) calendar days after they occur.

   b. Inform the client of the consequences of failure to report changes. Stress the penalties for fraud and misrepresentation.

   c. Explain to the client how to report changes and the required time frame for reporting changes.

   d. Inform the client about computer matches in which the county dss participates.

   e. Give the client a copy of the fraud pamphlet (DSS-8627). Explain the meaning of fraud.

(V.A.4.)

f. If the client's living standards appear to exceed his income, question the client regarding unreported income.

g. Ask the client about any changes that have occurred since application or the last review.

B. Documentation and Verification

Thorough documentation and verification provides the caseworker necessary information for the next review or for a possible fraud case and avoids erroneous eligibility decisions and undetected cases of fraud. The following procedures are recommended at all applications and reviews as a method of fraud prevention:

1. Complete an On Line Verification (OLV) inquiry to ensure each client does not already receive assistance in your county or another county. Document the results of the inquiry.

2. Complete inquiries, using all ssn's provided. Check all paper matches.

3. Document and verify all eligibility factors as required in policy.

4. When a change is anticipated, flag the case for review.

C. Other Preventive Measures

1. Intra-agency

a. Establish communications among the various units in the county dss. Fraud prevention is the responsibility of the entire agency, developing a systematic way to report changes and exchange information is key.

b. It is advised that the Program Integrity team conduct periodic training to educate dss employees who work in benefits eligibility and in services, regarding what Program Integrity does. Training should include the following:

(1) Interviewing skills and techniques.

(2) What constitutes misrepresentation and/or fraud.

(3) How to report suspected fraud and/or misrepresentation to Program Integrity staff.

(V.C.1.b.)

(4) The difference between a front-end referral and a regular referral.

(5) An overview of what steps the investigator takes when investigating a referral.

c. It is recommended that each county dss devise a plan to insure that every caseworker and social worker involved with a client/family communicate changes in the situation to each other, in an effort to prevent agency responsible errors.

2. Inter-agency

To obtain prompt and accurate information needed to determine eligibility, it is important to establish a good working relationship with other agencies, employers and institutions. Inform them of the program requirements and the importance of receiving prompt and accurate information.

3. Public awareness

Informing the public about your county dss's attempts to prevent fraud and abuse is important, both as a deterrent and as a public relations measure. Information regarding court actions, amount of recoupments, etc., should be made public. Publicize the phone number to call to report cases of possible fraud and abuse, stressing that such reports are confidential. If the public realizes they will be supported in their efforts, the county dss may be able to obtain much more information and cooperation.

VI. DETECTION

Referrals for investigations are received from the following:

A. State Office Referrals

Any leads received by DMA will be referred to the county dss in writing for investigation. The dss investigator should enter a pending referral in EPICS within seven days of the referral. If an IPV or an IHE is established, update the pending status in EPICS to agree with the findings. Follow the instructions in the EPICS User's Guide.

Regardless of the results of the investigation, the county must inform the Division of Medical Assistance Program Integrity Coordinator of the status of the investigation, in writing, within 60 days from the date of the referral letter.

(VI.)

B. Quality Assurance Reviews

During their regular review, Quality Assurance staff sometimes detects possible fraud or misrepresentation. Cases found in error or suspected of fraud or misrepresentation will be referred to the county dss for further investigation. The dss investigator should enter a pending referral in EPICS within seven workdays of date of the referral.

C. Private Sector and Other Agencies

If you receive information from other agencies, institutions, providers, other clients or private citizens, you are required to investigate the lead. Emphasize that such reporting will be kept confidential. An individual may be reluctant to report suspected fraud if he believes his name will be disclosed.

D. Agency Staff

During the application and review processes, the county dss staff may discover cases of possible fraud, abuse, or misrepresentation that need to be evaluated and/or investigated for a possible overpayment. At this point they should send a DMA-7057, Referral for Investigation, to the Program Integrity Unit. There are two types of in-house referrals. They are:

1. **Front-end Referral**: This referral is made during the application process prior to disposition of the case, and is made to prevent potential fraud. Usually the investigator has five working days to complete this investigation, and instruct the intake worker on their findings.

2. **Regular Referral**: This referral is made at any time other than during the application process. When a case is in active status, however, consideration should be given to cases still currently potentially ineligible in an effort to prevent further overpayments.

E. Other sources include but are not limited to:

1. Computer matches in OLV such as FSIS, EIS, ACTS, TPQY, SOLQ, ESC/UI, SDX, BENDEX, etc. Also check FRR (Financial Resource Report), BEER and the Veteran's Affairs matches.

2. Tax records (unreported personal property, automobiles, farm equipment)

3. Register of Deeds, and Clerk of Court records (marriage, transfers of property)

(VI.E.)

4. Social Security records (increases, lump sum payments, dual benefits)

5. Department of Motor Vehicles (DMV) records (vehicle license check, unreported registered vehicles, address)

6. Court records (support agreements, divorce decrees, prior convictions)

7. Department of Corrections (DOC) records (incarceration, parole, probation, work release)

8. HUD records (household composition, reported income)

9. School records (address, household composition, responsible party)

10. Utility company records (address, responsible party)

11. Collateral contacts (Landlords, neighbors, relatives)

12. Newspaper reports (births, deaths, marriages and transfers of property)

VII. INVESTIGATIONS

A. Preliminary Investigation

When a referral for possible Medicaid fraud or misrepresentation is received from any source, or when there is an indication a client may have received benefits to which he was not entitled, the county dss must conduct a preliminary investigation to assess whether eligibility has been correctly determined and documented according to policy regulations. You must also establish a pending claim in EPICS. Follow the instructions in the EPICS User's Guide.

1. Review all county dss benefits case records and systems (OLV, etc.) for that client, including Medicaid, TANF, and Food and Nutrition Services. These records should furnish basic information and clearly show the findings on all eligibility factors. Communicate with Service Workers to determine if there was information reported to them that would have affected eligibility.

2. It is necessary to ensure that the client understood and accepted responsibility for reporting changes in circumstances to the county dss in a timely manner.

    a. Determine from documentation and verification documents if an adequate explanation was given to the client regarding his rights and responsibilities.

(VII.A.2.)

b. Determine whether the client was offered assistance to obtain requested verifications at each contact with the county dss during the application process. This is necessary to ensure that the client understood and accepted responsibility for reporting changes to the county dss in a timely manner.

c. **If the county dss did not meet their obligation, any resulting overpayment is deemed an agency error and cannot be collected from the client.**

3. Determine from the case record if the information is already known to the agency.

   a. Information reported in a timely manner to any county dss staff is considered information known to the agency.

   b. **An overpayment resulting from information known to the agency but not communicated to the appropriate caseworkers is deemed an agency error and cannot be recouped from the client.**

   c. Caseworkers who worked with the case during the period in question are invaluable sources of information. Discussion with the caseworkers may clarify documentation and/or other critical points

4. If the preliminary investigation establishes the recipient's continuing eligibility, no further investigation is required.

   Example: A private citizen calls to report that a recipient's husband is employed. A review of the case record indicates that his income was reported and considered in determining her eligibility, or the change in income did not affect the family's eligibility.

5. If the preliminary investigation gives the county dss reason to believe fraud or misrepresentation has occurred conduct a full investigation and create a referral in EPICS.

B. Verification of Reported Information

Continue a full investigation until legal action is initiated and the case is resolved by seeking recoupment of the overpayment, or the case is closed due to insufficient evidence to support the allegations, or for other reasons.

1. Verify the reported information to establish whether fraud/misrepresentation exists. Obtain the verifications by written or verbal contact with the recipient, employers, financial institutions, other agencies, and collaterals, etc.

(VII.B.)

2. Document your findings in the investigative case file. Include complete names and dates.

3. If you are unable to substantiate the allegations, document the record and close the investigation. Indicate in EPICS that this was an unsubstantiated claim. Refer to the EPICS Users Guide for instructions.

4. If verifications substantiate that fraud/misrepresentation exists, schedule an interview with the recipient.

C. Building the Investigative File

To build an investigative file, clearly document each step taken in the application/authorization process. Certain information needs to be included when available, including, but not limited to the following:

1. All application and recertification booklets.

2. All narratives pertaining to the overpayment from the eligibility file.

3. Calculations of benefits.

4. All supporting verifications to include, but not limited to the following:

   a. Wage stubs and/or affidavits

   b. Bank records, and court documents

   c. Collateral statements, postal letters

   d. All computer matches

5. An investigative narrative needs be kept on every contact with the debtor and on any action taken on the case. Each entry should be dated and initialed by the investigator. Use full sentences. Quote what was actually said whenever possible.

6. Be sure you have reviewed all benefit files in your agency to determine what information the client provided, and what was verified. Communicate with Service Workers. Remember, if the client reported something to anyone within the dss, it is considered as "known to the agency." If dss failed to follow up in a timely manner, any resulting overpayment is considered an agency error.

(VII.)

D. Investigative Interview

1. Conduct an interview with the client and/or representative if a case appears to be client responsible fraud or misrepresentation.

2. The investigative interview with a client suspected of fraud or misrepresentation can be the most important element of the investigation. It is important to employ techniques of skillful interviewing.

   a. Interview the client in an area where you will have privacy. Inform the client he is free to leave at any time.

   b. Inform the client you are investigating for possible overpayments. Ask the client if there is anything he wishes to tell you that he has not previously revealed to the county dss.

   c. Discuss the subject of fraud. Explain the client's rights and responsibilities to determine if the client understands the concept of fraud. Ask the client to explain his rights and responsibilities in his own words.

   d. Review the case file with the client. Cover the eligibility points in question. Confirm that the client came in to make application and did in fact make the statements documented on the signed form(s).

   e. Ask again if the client wishes to change any of the statements made or if he has any new information to report.

   f. Use open-ended questions and mirror questions. Allow the client as much time as needed to answer.

      Example: "How did you say you disposed of the property?" "Help me understand your statement about your income and why you did not report it."

3. When the client continues to affirm that all statements previously made are true, confront the client with the known facts.

   a. If the client makes a statement that is known to be false, present the known facts as well as any evidence gathered to substantiate them.

   b. If the client admits wrongdoing and wishes to acknowledge the truth, take a statement and have the client sign and date it. It is recommended that a witness also sign the statement. Also review the case file and have the client identify those statements that are false.

4. Document the interview thoroughly.

VIII. CALCULATING OVERPAYMENTS

This section provides rules for establishing overpayments and is applicable to all Adult coverage groups. To properly determine an overpayment, the investigator must have full knowledge of all Medicaid programs and access to present and past eligibility policy.

A. General Rules

1. Based on the verified unreported information, determine the period(s) of ineligibility for each assistance unit (a.u.) member. The period of ineligibility may encompass a whole or partial c.p.

2. Redetermine eligibility as if the information had been reported timely by the recipient.

3. Allow time for changes:

   a. Allow 10 calendar days for the client to have notified the county dss of the change. For income cases, changes must be reported within 10 calendar days of the **receipt** of the changed income.

   b. Allow another 10 work days for Timely Notice (DSS-8110) to the client of the change in eligibility.

      Example: In an ongoing MAA-Q case, client starts working on 07/02/07. He gets paid monthly and he receives his first paycheck on 08/01/07. The client has until 08/11/07 to report the income. The client reports by the 13th (the 11th is a Saturday). The worker acts on the reported information and sends a notice to the client on 08/14/07. The first month a change could be effected is 09/07.

4. If any a.u. member is determined to be ineligible under the original coverage group, determine if the a.u. member could have been eligible under any other coverage group had the information been reported correctly and timely.

   Example: A recipient who is ineligible as Categorically Needy (CN) may be eligible as Medically Needy (MN) with a deductible.

   Example: A recipient who is ineligible for MAA-Q may be eligible for MQB-Q or MQB-B. This would decrease the amount of the overpayment.

5. Use the appropriate resource and income levels for the period of ineligibility. Refer to the MAABD & MQB Income History and the MAABD Reserve History for current and archived Income and Resource Limits.

   a. For cases with unreported/changed resources verify available resources as of the first moment of each month.

   b. For cases with unreported/changed income, compute eligibility separately for each certification period, using the verified base period income. Project the income over the remainder of the c.p. as if the income had been reported correctly and/or timely by the client.

   c. If multiple changes occur, re-budget each change in the order in which it occurred. Refer to MA-2250, V. for an explanation of what constitutes a change in income.

6. Once the period of ineligibility is established, request a Medicaid/NCHC Recipient Profile from the Division of Medical Assistance via the DMA-7063 to establish the overpayment amount.

   a. Complete the required information for each member of the assistance unit who is ineligible. For instructions on how to order Medicaid/NCHC Recipient Profiles, refer to section XVI. below.

   b. It is not necessary to request a profile for long-term care cases with an understated liability

7. Buy-In for Part A and/or Part B Medicare Premiums

   a. **Do not** include the amount of the Medicare premiums in the overpayment for recipients ineligible due to excess income or transfer of assets.

   b. For all recipients who are ineligible due to excess resources or other categorical requirements, include the amount of the Medicare premiums paid during the overpayment period in the total amount of the claims paid to determine the overpayment.

B. Computation of Overpayments due to Excess Income

1. Determine the period(s) in which the recipient was ineligible for CN coverage due to income that exceeded the income limit.

(VIII.B.1.)

a. The period of ineligibility may encompass a whole or partial c.p., several contiguous c.p.'s, or in the case of multiple changes in income, there may be non-contiguous periods of ineligibility.

b. In determining the point of beginning ineligibility, allow adequate time for changes to have been reported and for appropriate action to have been taken by the county dss.

2. Change Discovered During the Current Certification Period

a. Verify and project changed or unreported income based on policy requirements.

b. If the recipient has an unmet deductible, send a timely notice to increase the deductible. There is no overpayment since the recipient was not authorized for Medicaid.

c. If the recipient is authorized because there is no current deductible or the current deductible has been met, and there is time in the current certification period (c.p.) to take action to revise the deductible, send timely notice to increase the deductible.

(1) If the recipient incurs enough medical expenses to meet the additional deductible prior to the end of the c.p. (including old bills), there is no overpayment.

(2) If the recipient does not incur enough medical expenses to meet the additional deductible, apply all allowable expenses to the additional deductible to determine the amount of the unmet deductible.

(3) Request a Medicaid/NCHC Recipient Profile for the period authorized. Refer to XVI. below for instructions on how to read Medicaid/NCHC Recipient Profiles and determine the amount of claims paid on behalf of the client during the period of ineligibility.

(4) Compare the amount of the unmet deductible to the amount of expenses paid by Medicaid. The overpayment is the lesser of the two amounts.

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3. If the change is discovered after the c.p. or it is too late in the current c.p. to take action to revise the deductible, determine the overpayment as follows:

(VIII.B.3.)

a. Verify and project changed or unreported income based on policy requirements.

b. If the original deductible was never met and there was no authorization, there is no overpayment.

c. If the original deductible was met or the recipient had no deductible, send a DSS-8110 giving the recipient 10 work days notice of the additional or new deductible amount.

(1) Allow the recipient the opportunity to provide any additional medical expenses to meet the deductible.

(2) If the recipient meets the additional deductible, there is no overpayment.

(3) If there is an unmet deductible, request a Medicaid/NCHC Recipient Profile for the period of ineligibility.

(4) Compare the amount of the unmet deductible to the amount of expenses paid by Medicaid during the period of ineligibility. The overpayment is the lesser of the two amounts.

4. Income Example:

05/02/07 – A single woman applied for MAD-N. She reported that her only source of income was $638 from Social Security. Her application was approved with a certification period from 05/01/07 to 04/30/08. The client reported she had a $5,000 unpaid bill from 01/07. Client did not qualify for retro.

05/14/07 – The client began working.

06/18/07 – The client received her first monthly check for $1245 which she did not report. Had client reported her earnings timely by 10 calendar days (6/28/07), and another 10 workdays for a timely notice, the change would have affected her Medicaid beginning 08/07.

01/01/08 – Client's Social Security increased from $638 to $650.

(VIII.B.4)

03/03/08 – The client came to county dss for a redetermination of eligibility. She reported her Social Security increase. During the review, the caseworker discovered through OLV that the client had wages beginning the second quarter of 2007. The client admitted she had been working but had forgotten to report it. The caseworker sent the employer a letter to verify earnings.

03/10/08 – The employer verified the client's monthly earnings of $1245 beginning in June 2007. Since the income exceeded the CN income limit, Medicaid was evaluated with a deductible. The client was sent a 10 day notice to advise her of the new deductible. The deadline to respond was 03/24/08.

03/20/08 – The client provided the unpaid $5000 unpaid bill from 01/07. Client said she did not expect to have bills to meet the deductible for ongoing eligibility.

04/01/08 – The client was sent a timely notice to terminate benefits effective 04/30/08.

Calculate an overpayment following the rules below:

Rule: Divide a 12-month c.p. into two 6-month c.p.s when there is excess income for CN eligibility.

In this example, the c.p.s were divided as follows: 05/01/07-10/01/07 and 11/01/07 – 04/30/08.

Rule: Verify unreported base period income for each certification period.

Rule: Re-budget using verified income during the overpayment period. Re-budget each certification period separately.

In the first c.p. count the client's income from 06/07 to 10/07. In the second c.p., budget 11/07 and 12/07 separately from 01/08 - 04/08 because the client's income changed in 01/08 due to the COLA increase.

Rule: Determine the deductible for each certification period.

(VIII.B.4.)

Calculate the deductible as follows:

May 2007 thru October 2007	***November 2007 thru April 2008***
Deductible months:	***Deductible months:***
June 2007 – October 2007	***November 2007- December 2007***
$638.00 Original RSDI	$638.00 Original RSDI
- 20.00 Deduction	- 20.00 Deduction
= $618.00	= $618.00
$1245.00 Wages	$1245.00 Wages
- 65.00 Earned Income Deduction	- 65.00 Earned Income Deduction
= $1180.00 / 2	= $1180.00 / 2
= 590.00 Net Earned	= 590.00 Net Earned
+ 618.00 RSDI	+ 618.00 RSDI
= $1208.00	= 1208.00
- 242.00 Maintenance	- 242.00 Maintenance
= $966.00 Excess Income	966.00 Excess Income
X 5 Months 06/07-10/07	X 2 Months 11/07-12/07
= **$4830.00 Deductible**	= **$1932.00 Deductible**
	January 2008 thru April 2008
The client provided the $5,000 bill	$ 650.00 RSDI-COLA Increase
from 01/07.	-20.00 Deduction
	= 630.00
$5,000	$1245.00 Wages
-$4,830	- 65.00 Earned Income Deduction
$170 Remainder unpaid medical	= $1180.00 / 2
	590.00 Net Earned
	+ 630.00 RSDI
	$1220.00
	- 242.00 Maintenance
	=978.00 Excess Income
	X 4 Months 01/08 to 04/08
	$3912.00
	+$1932.00 Months 11/07-12/07
	$5844.00 Deductible 11/07-04/08
	- 170.00 Remainder unpd medical
	$5674.00 Unmet deductible

The unmet deductible for 11/07 to 04/08 is $5,674.
REVISED 03/01/11 - CHANGE NO. 05-11

Rule: Send a DSS- 8110 to notify the client of the new or revised deductible, allowing the client time to provide unpaid bills to meet the deductible.

Since the client provided the $5000 bill from 01/07, she was able to meet the deductible of $4,830 for the first cert period ($5000-$4830= $170). The remainder $170 was applied to the second cert period decreasing the deductible amount to $5,674.

Rule: Determine the amount of claims paid by Medicaid during the periods of ineligibility.

A Medicaid/NCHC Recipient Profile was requested for 11/07-04/08. The Recipient Profile indicated that Medicaid paid $1,500 in medical expenses during ineligible period.

Rule: Compare the amount paid by Medicaid to the amount of the unmet deductible. **The amount of the actual overpayment is the lesser of the two amounts.**

The total overpayment in this case is $1,500 because it is less than the deductible amount of $5,674.00.

5. If ineligibility is the result of a client error in determining the amount of expenditures for medical care applied to the deductible, the amount of the overpayment is the lesser of:

   a. The amount of Medicaid payments made on behalf of the recipient, or

   b. The difference in the actual amount of incurred expenses and the amount of the deductible.

      Example: The deductible for May-October was $865. Based on the medical charges provided, the recipient was authorized effective June 2. It is later discovered that a $115 charge that had been applied to the deductible was incorrectly applied. (The recipient forged her name on the bill but it was in fact for services rendered to an individual not in the b.u.) The profile shows that $1055 was paid for medical charges during the c.p. Subtract the actual amount of incurred expenses that could be applied to the deductible ($750) from the deductible amount ($865), and compare this amount ($115) to the claims paid ($1055). The lesser amount ($115) is the overpayment amount.

      NOTE: This is applicable only if the error was on the part of the client. If the county dss makes an error in applying expenses to the deductible, it is an agency error and cannot be recouped from the client. Therefore no claim should be entered in EPICS.

C. Overpayment Methodology for Excess Resources

1. Determine the period(s) in which the recipient was ineligible due to resources that exceeded the reserve limit.

   a. The period of ineligibility may encompass a whole or partial c.p., several contiguous c.p.'s, or in the case of reserve fluctuating above and below allowable limits, there may be non-contiguous periods of ineligibility.

   b. In determining the point of beginning ineligibility, allow adequate time for changes to have been reported and for appropriate action to have been taken by the county dss.

   c. If the recipient states that resources are for burial purposes, apply the burial exclusion policy. This policy can be applied retroactively, allowing the recipient to use cash funds to purchase burial assets and exclude up to the $1500.00 burial exclusion limit. See MA-2230 for detailed information regarding retroactive burial exclusions.

2. Determine excess reserve for each separate period of ineligibility.

   a. Verify all resources available to the recipient during each period of ineligibility.

   b. Determine the dollar amount by which reserve most exceeded allowable limits during each period in question.

      (1) Verify the reserve amount for each month using the first moment of the first day of each month.

      (2) Compare the reserve for every month during the period of ineligibility. Use the largest amount in the overpayment calculation.

   c. Notify the recipient on the DSS-8110 of the amount of excess reserve in each period of ineligibility and request verification, if any, of reduction of reserve.

3. Determine the amount paid by Medicaid during each separate period of ineligibility.

   a. Request a Medicaid/NCHC Recipient Profile via the DMA-7063 to DMA Quality Assurance.

(VIII.C.3.)

b. If there is more than one period of ineligibility, request a Medicaid/NCHC Recipient Profile for each separate period of ineligibility under the heading entitled "Dates of Service." Refer to XVI. for complete instructions on how to request Medicaid/NCHC Recipient Profiles.

4. Determine the amount of the overpayment.

a. Determine the overpayment for each period of ineligibility separately.

b. The amount of the overpayment for each period of ineligibility is either the amount paid by Medicaid during that period, or the highest dollar amount by which reserve exceeded allowable limits, whichever is less.

c. If there is more than one period of ineligibility, add together the overpayments from each period to get the total amount of the overpayment.

d. If the amount of the overpayment is based on the amount of paid claims, include the amount of Medicare premiums paid during the overpayment period(s). Determine this amount by verifying when the Buy-In became effective. Then multiply the premiums paid by the state, times the number of months the client was ineligible. Refer to the History of Medicare Deductibles, Co-Payments and Premiums, on the DMA website, for current and archived Medicare premiums.

e. If the amount of excess reserve is less than the claims paid as reported on the profile, it is not necessary to include the Medicare premiums as the overpayment is based on the lesser amount of excess reserve.

Example: Recipient was found eligible and authorized June-November with no reserve. It is discovered at a subsequent review that the recipient had a certificate of deposit with a balance of $8,700, resulting in excess reserve of $6,700. Recipient provides verification that reserve was reduced to allowable limits on October 30. The period of ineligibility is June 1-October 30. During this period Medicaid paid $936 in claims plus $183 in Medicare premiums for a total of $1,119. The overpayment is $1,119 as this is less than the amount of excess reserve.

Example: Recipient was authorized March-August with countable reserve of $275. A savings account is later discovered causing excess reserve of $725. During this period Medicaid paid $8,922 in claims. The overpayment is $725, as this is less than the amount of claims paid. Note: It is not necessary to include the Medicare premiums in the amount of the claims paid in this example, as the excess reserve is the lesser amount.

(VIII.C.4.e)

Example: MAA-N recipient was found eligible and authorized April-September and October-March. At the next review it is discovered that the recipient failed to report a savings account that caused excess reserve in the amount of $450 from initial authorization. Recipient provides verification that reserve was reduced on September 2. However, by January 1 reserve again exceeded allowable limits by $300.

The first period of ineligibility is April -September with excess reserve of $450. A recipient profile shows a total of $526 paid in claims. The overpayment for this period is $450, which is less than the amount paid in claims.

The earliest the case could have been terminated for the second period of ineligibility was January 31 due to timely notice requirements. Therefore the second period of ineligibility is February - March with $300 excess reserve. A payment history profile shows a total of $45 paid in claims plus $82 in Medicare premiums. The overpayment for this period is $127, which is less than the amount of the excess reserve.

The total amount of the overpayment for both periods of ineligibility is $450 + $127 = $577.

Note: Reserve must be established based on the first moment of the first day of each month.

f. If there are separate periods of ineligibility which are separated by gaps in authorization (not by periods of eligibility), there is only one overpayment based on either the maximum amount of excess resources for the periods or the amount paid by Medicaid for all the periods, whichever is less.

Example: A recipient authorized May-October is terminated at the end of the c.p. due to failure to complete the review. The recipient re-applies and is authorized January-June. At the review at the end of the latter c.p., it is discovered that the recipient had an unreported bank account that caused excess resources during both c.p.'s. The maximum excess resources for May-October were $660 and for January-June were $720. The total amount of claims paid for both periods was $1,095. The overpayment amount is $720 (the lesser of $1,095 and $720).

D. Overpayment Methodology for Transfer of Assets

Depending on when the transfer took place, different procedures apply to overpayments due to Transfer of Assets occurring before or after November 1, 2007. Refer to MA-2240 Transfer of Assets for policy clarification.

(VIII.D.)

1. Transfer of asset sanctions applies to institutionalized recipients for payment of cost of care (long-term care) in:

   a. Nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR), or

   b. Swing bed or inappropriate level of care bed in a hospital, or

   c. CAP waiver programs, PACE, in addition,

   d. **After February 1, 2003 and prior to November 1, 2007**

      In-Home-health Services and supplies for private living arrangement

   e. **After November 1, 2007**

      In home health services and supplies for private living arrangement after being sanctioned for institutional services, and a portion of the sanction period remains after the individual stops receiving institutional services. Refer to MA-2240 for procedures and regulations applicable to transfer of assets at the time of the transfer.

2. Three separate calculations are required to determine the amount of the overpayment when the LTC recipient, his financially responsible spouse or his representative does not report transfer of assets:

   a. Calculate the overpayment for any period of authorization prior to the transfer in which the recipient was over the allowable resource limit.

   b. Based on the date of the transfer calculate the overpayment for the period of the sanction for assistance with cost of care in the institution.

   c. Determine eligibility based on PLA budgeting to calculate the overpayment based on the unmet deductible for other medical costs during the sanction period.

3. Determine the amount of any overpayment for unreported assets that exceeded allowable limits prior to the transfer following procedures in VIII.C. above.

4. Determine if the LTC recipient should have been sanctioned for transfer of assets. Refer to MA-2240 V. If no sanction is applicable, the overpayment is computed based on the excess resources prior to the date of the allowable transfer.

(VIII.D.4.)

a. If the recipient transferred property, determine starting points:

(1) Applications prior to November 1, 2007 – Individuals who first applied for Medicaid in any category on or after February 1, 2003, but prior to November 1, 2007, the starting point is the date of the first application for Medicaid.

(2) Applications on or after November 1, 2007 – Individuals who first applied for Medicaid in any category prior to February 1, 2003 or on or after November 1, 2007, the starting point is the earliest date the recipient is institutionalized or request CAP, PACE, **and** applies for Medicaid.

b. The lookback date is the earliest time on or after which all transfers of assets are reviewed for a recipient requesting or receiving institutionalized services. See dates below:

Lookback Dates

	Starting point prior to 11/01/10	Starting point 11/01/10 or later but prior to 11/01/12	Starting point 11/01/12 or later
Lookback Date	36 months prior to starting point for most transfers. 60 months for transfers to annuities or trust	11/01/07 for most transfers; 5 years prior to starting point for transfers to trusts and annuities	5 years prior to starting point for transfers of all types

5. Determine the sanction period.

a. **Transfers occurring prior to November 1, 2007** – The length of the sanction begins with the month of transfer. Refer to MA-2240 XII.B. for detailed instructions.

(1) Total the uncompensated value of transfers in the lookback period

(2) Divide the total uncompensated value by $5,000.

(3) Round this number to the lowest whole number

(4) The result is the number of months of sanction

(VIII.D.5.)

b. **Transfer occurring on or after November 1, 2007** - Refer to MA-2240 XII C. and to the DMA-5181, Calculating Penalty Period, to assist in calculating the sanction period.

6. If a sanction is applicable, determine the amount Medicaid paid for cost of care during the sanction period. Request a Recipient Profile via the DMA-7063. Refer to XVI. for instructions on how to request a Medicaid/NCHC Recipient Profile.

   a. The DMA Recipient Investigations Coordinators will review the Recipient Profile to determine which claims are considered non-covered during the transfer of assets sanction.

   b. The Coordinator will prepare a letter for the investigator, detailing the amount of the non-covered claims to be included in the overpayment. If there are questions regarding claims, please contact DMA at 919 647-8000.

7. Determine the total amount of the overpayment for the sanctioned period.

   a. Compare the amount of the uncompensated value of the transferred assets to the total amount Medicaid paid for cost of care during the sanction period.

   b. The overpayment is the lesser of these two.

8. Compute eligibility for other medical services for each c.p. in the sanction period based on PLA budgeting. If a deductible results:

   a. Determine the amount Medicaid paid for medical services other than cost of care during the sanction period by requesting a Medicaid/NCHC Recipient Profile.

   b. Compare the amount of the unmet deductible for each c.p. to the amount of claims paid for other medical services in each c.p. The overpayment is the lesser of the two.

   c. If there is more than one c.p. add the totals for each together.

      Note: If the sanction period has not been exhausted, apply the remaining months of sanction to the ongoing case and rebudget based on PLA budgeting.

(VIII.D.)

9. Add the amount of the three calculations, excess reserve, sanction period and unmet deductible. Compare this total to the amount of the uncompensated transfer and/or excess reserve, whichever is greater. The overpayment amount is the lesser of the two. The total overpayment can never exceed the total amount of the uncompensated transfer or the excess reserve, whichever is greater.

10. Transfer of Assets Examples

a. **Transfer prior to November 1, 2007**

07/11/07 – A single individual transfers a Certificate of Deposit worth $24,000.

08/01/07 – The individual enters a nursing facility.

08/13/07 – The individual applies for MAA for help with cost of care. He reported no resources and income of $875 from SSA. The case was authorized effective 8/01/07-1/31/08

12/05/07 - The county dss verifies that the individual had transferred the Certificate of Deposit worth $24,000. The case is referred to Program Integrity.

Step 1- Determine if there was excess reserve prior to the transfer.

There was no excess reserve to consider because the transfer was made on 07/11/07, prior to the application date of 08/13/07.

Note: If transferred assets are returned to the recipient, do not apply a sanction. Count the value of the returned assets for the entire period including the time the resources were not in the client's name.

Step 2- Determine the sanction period.

The starting point in this case is 08/13/07, the date of the first application for Medicaid. Look back date is 08/13/04, 36 months prior to the starting point.

1.)	Total uncompensated transfers	$24,000
2.)	Divide by private NF rate	$ 5,000
3.)	Equals number of sanction months	4.80

(VIII.D.10.a)

The 4.80 is rounded down to 4. The four-month sanction begins from the month of transfer July 2007 to October 2007.

Step 3 – Determine the amount of the overpayment for the sanctioned period.

The agency verified through DMA that the total paid for "cost of care" from 8/1/07 – 10/31/07 was $20,000.00. The $20,000 is less than the $24,000 transfer amount. The amount of $20,000 will be used to compute the overpayment. Other paid expenses such as Rx, are not included at this, at this point.

Step 4 - Budget PLA with a deductible for the ineligible months

The client is ineligible for full Medicaid because her $875 SSA benefits exceeds income limit. Therefore, we calculate a deductible.

Ineligible months in c.p: 8/01/07-10/31/07

$ 875	
-242	PLA Maintenance
= $ 633	Excess Monthly Income
x 4	Months
= $ 2,532	Deductible for 08/07-10/07

Client's total deductible for the four months he is ineligible for cost of care is $2,532. The cost of care is not an allowable expense toward the PLA deductible during the sanction period.

According to the Medicaid Profile, the amount Medicaid paid for medical services other than the cost of care from 08/07 – 10/07 was $200.

Client was advised of the deductible and given the opportunity to provide old or new bills. The client did not provide bills. Since the $200 Medicaid paid is less than the deductible amount of $2,532, the $200 will be used to compute the overpayment.

Step 5 – Add the amount of the three calculations to determine the overpayment

$ 0.00	Excess Reserve
$20,000.00	Cost of Care expenses
$ 200.00	Cost of Services for other than cost of care
$20,200.00	Total Overpayment

(VIII.D.10.a)

The overpayment amount of $20,200 is entered into EPICS with Service Code 11. The individual is eligible for Medicaid for LTC 11/01/07 – 01/31/07.

b. **Transfer on or after November 1, 2007.**

07/11/08 – A single individual transfers a Certificate of Deposit worth $24,000

08/01/08 – The individual enters a nursing facility.

08/13/08 – An individual applies for MAA for help with cost of care. He reported no resources and income of $875.00 from SSA. The case was authorized effective 8/01/08-1/31/09

12/05/08 - The county dss verifies that the individual had transferred the Certificate of Deposit worth $24,000. The case is referred to Program Integrity.

Step 1- Determine if there was excess reserve prior to the transfer.

There was no excess reserve to consider because the transfer was made on 07/11/08, prior to the application date of 08/13/08.

Step 2- Determine the sanction period

The starting point in this case is 08/01/08, the earliest date the individual was institutionalized and applied for Medicaid. The Lookback date is 08/01/05, 36 months prior to the starting point.

1.) Total uncompensated transfers $24,000
2.) Divide by private NF rate $ 5,000
3.) Equals number of months 4.84
4.) Determine whole month sanction period by Counting forward from date otherwise eligible
08/01/08 through 11/30/08
5.) Enter fractional month (from 3 above) and multiply by 31.
.84 X 31 = 26.04
6.) Add 26 days to the sanction in 4 above. Drop partial day.
08/01/08 through 12/26/08

The total sanction period is from 08/01/08 through 12/26/08.

Step 3 – Determine the amount of the overpayment for the sanctioned period

(VIII.D.10.b.)

The agency verified through DMA that the total paid for "cost of care" from 8/1/08 – 12/26/08 was $25,000.00. The cost of care amount of $25,000 is more than the $24,000 the recipient transferred. The $24,000 will be used to compute the overpayment. Other paid expenses such as Rx, are not included at this, at this point.

Step 4 - Budget PLA with a deductible

The client is ineligible for full Medicaid because her $875 SSA benefits exceeds income limit. Therefore, we calculate a deductible.

PLA Certification period: 8/01/08-12/31/08

$ 875	
-242	PLA Maintenance
= $ 633	Excess Monthly Income
x 5	Months
= $ 3,165	Deductible for 08/07-12/07

Client's total deductible for the five months he is ineligible for cost of care is $3,165. The cost of care is not an allowable expense toward the PLA deductible during the sanction period.

According to the Medicaid Profile, the amount Medicaid paid for medical services other than the cost of care from 08/08 – 12/07 was $200.

Client was advised of the deductible and given the opportunity to provide medical bills. The client did not provide any bills to reduce his deductible. The $2,200 Medicaid paid is less than the deductible amount of $3,165. The $2,200 will be used to compute the overpayment.

Step 5 – Add the amount of the three calculations to determine the overpayment

$ 0.00	Excess Reserve
$24,000.00	Cost of Care expenses
$ 2,200.00	Cost of Services for other than cost of care
$26,200.00	Total Overpayment

The overpayment amount of $26,200 is entered into EPICS with Service Code 11. The recipient is eligible for Medicaid for LTC from 12/27/08 – 01/31/09.

(VIII.)

E. SA Money Payment Cases

1. If a SA recipient is found to be ineligible for money payment, assess the recipient's eligibility for Medicaid under any other coverage group during the period of SA ineligibility.

2. If the recipient would have continued to be eligible for Medicaid only there is no overpayment.

3. If the recipient would have been eligible for Medicaid with a deductible, refer to the instructions in B. above to determine if there is a Medicaid overpayment.

4. Refer to SA manual for SA overpayments. The cash portion of SA overpayments does not go into EPICS

F. Long Term Care Cases

When there is a change in patient monthly liability (pml) due to unreported income, calculate the overpayment as follows:

1. Verify the amount of the unreported income.

2. Determine when the pml would have changed had the income been reported timely, allowing time for notification of the change.

3. If applicable, correct the ongoing pml, allowing for timely notice of the change.

4. If the correct liability is less than the nursing facility's Medicaid reimbursement rate, the amount of the overpayment is the total of the difference between the original pml and the correct pml for each month.

5. As a rule it is not necessary to request a recipient profile for patient liability.

   Example: A recipient with income-producing property is authorized for January-June with a pml of $350 per month. It is discovered and verified on May 5 that the recipient's countable income increased by $50 per month beginning March 1 because of an increase in the rent she is paid. The pml is revised effective June 1, leaving an understated liability for April and May. Had the change been reported within 10 days by the recipient's representative and the county dss given timely notice, the pml would have been increased effective April 1. The total overpayment is $100, $50 for each of the 2 months.

(VIII.F.)

6. If the unreported income causes the recipient's total countable monthly income to exceed the nursing facility's Medicaid reimbursement rate, private rate, or all other predictable medical expenses (MA-2270, V.B.), then the recipient was ineligible for assistance with the cost of care. Budget the recipient PLA with a deductible. Refer to MA-2270, XIII.

   a. Request a Medicaid/NCHC Recipient Profile for the period of ineligibility for payment of cost of care. Follow the instructions in XVI., Medicaid Profiles, to determine the total amount paid by Medicaid for "Room and Board and Ancillary charges".

   b. Compute a monthly deductible, subtracting from the recipient's income any allowable deductions.

   c. Beginning with the first month of ineligibility for help with cost of care, multiply the monthly deductible by the number of ineligible months to arrive at the total deductible. If the income varied, use the maintenance allowance adjustment to compute the total deductible.

   d. If there was no deductible the recipient would have been authorized for Medicaid except for cost of care. The overpayment is the amount paid for cost of care.

   c. If there is a deductible, compute the overpayment as follows:

      (1) Apply any medical expenses not covered by Medicaid to the deductible.

      (2) Compare the remaining unmet deductible to the amount of claims paid for other medical services. The overpayment is the lesser of the two amounts.

      (3) Add this amount to the amount paid for cost of care. This is the total overpayment.

7. In some cases Medicaid pays less than the assigned PML because Medicare covered the hospitalization, except for the Part A deductible, and the SNF charges for a limited period of time. See MA-2270, XIV., and Table B, for more details about Medicare coverage in hospitals and SNF.

   a. It is not unusual for a person to go from the hospital to the LTC facility and for Medicare to continue to pay. When the LTC client has Medicare, and you discover an understated liability, ask the client or Nursing Facility about any hospitalizations or Medicare covered days during the overpayment period.

(VIII.F.7.)

b. If Medicare payment is involved request a recipient profile to determine what was paid by Medicaid. Compare this total amount to the total understated liability. The lesser of the two amounts is the Medicaid overpayment.

G. Evaluating Ineligible M-AABD Recipients for MQB-B

1. Unreported Income

When a recipient is determined to have been ineligible for full MAABD or MQB-Q coverage due to unreported income, evaluate the recipient's eligibility for MAABD-M and MQB-B during the period of ineligibility.

a. Using actual verified income, re-compute the recipient's eligibility for full coverage. Refer to B. above for calculating overpayments based on revised deductibles.

b. Compare the verified income to the income limits for MQB-B to determine if the recipient continues to be eligible for limited coverage.

c. If ineligible for MQB-B, evaluate for all other MQB classifications, and for MWD.

d. Notify the recipient on the DSS-8110 of their MAABD-M deductible status.

e. Also advise the recipient on the same DSS-8110 of their status for other MQB classifications.

2. Unreported Resources

When a MAABD-N recipient is determined to have been ineligible for full coverage due to unreported resources, evaluate the recipient's eligibility for MQB-Q and MQB-B during the period of ineligibility.

a. Compare the actual verified resources to the MQB-B reserve limits to determine if the recipient continued to be eligible for limited coverage.

b. Notify the recipient on the DSS-8110 of any change in current eligibility, including their eligibility for MQB-Q.

3. Request a recipient profile for the overpayment period.

a. If the recipient is eligible for MQB-Q, you will count only the total paid for non-Medicare covered services in the overpayment amount. See XVI. Medicaid Profiles for further instructions.

(VIII.G.3.)

b. Medicare covered services are what we call crossover claims (claim types O, X, and W). Do not count benefits paid on these claim types. The remaining claim types are non-Medicare covered claims and any benefits paid on these would count toward the overpayment. See XVI., Medicaid/NCHC Recipient Profile, for further instructions.

c. If the recipient is eligible for MQB-B, MQB-Q, MQB-E, or MWD only, all payments made for medical services are considered an overpayment.

d. If the client would have had a deductible, compare the amount Medicaid paid to the amount of the deductible. The overpayment is the lesser of the two.

f. If the recipient would have been eligible for MQB-Q during the overpayment period, the amount paid for MQB-Q covered-services are excluded from the overpayment.

Example: Recipient was authorized for MAA Q. After applying the Burial Exclusion, countable resources verified at application were $800, which was less than the allowable limit of $2,000. During the review process it is verified that the recipient had an unreported $3,000 certificate of deposit. This caused $1,800 excess reserve ($3,800 - $2,000) for MAA for the entire c.p.

However, $3,800 is less than the $4,000 reserve limit for MQB-Q. Therefore the recipient remains eligible for MQB-Q for the entire c.p. The Medicaid/NCHC Recipient Profile indicates that Medicaid paid a total of $750 for MQB-Q covered services and $183 for non-MQB-Q covered services. The amount of the overpayment is $183, the lesser of the amount paid for non-MQB-Q covered services and the excess reserve.

H. MQB-Q Ineligible Cases

1. If a recipient is found to be ineligible for MQB-Q due to unreported resources, evaluate for MAABD-M. Follow the instructions in C. above to calculate the amount of the overpayment. These recipients are not eligible for MAABD-N as the reserve limit is lower for that coverage group. These recipients may be eligible for MAABD-M with a deductible if reserve is reduced during the period of ineligibility.

2. If a recipient is found to be ineligible for MQB-Q due to unreported income, evaluate the recipient's eligibility for MAABD-M with a deductible. Follow the instructions in B. above. If the recipient is unable to meet the deductible, the amount of the overpayment is the lesser of the amount Medicaid paid or the amount of the deductible.

(VIII.H.)

3. For ineligible MQB-Q recipients, determine the amount Medicaid paid by requesting a Medicaid/NCHC Recipient Profile.

4. If a recipient is found ineligible for MQB-B, MQB-Q, MQB-E or M-QB-and did not receive MAABD or MQB-Q, do not request a Medicaid/NCHC Recipient Profile. The only service paid by Medicaid is the Medicare Part B premium or a portion of the Medicare Part B premium and this does not appear on a profile. Determine the amount of premiums paid and use this amount to establish the overpayment. Refer to the History of Medicare Deductibles, Co-Payments and Premiums, on the DMA website.

I. Potential SSI Medicaid Overpayments

When the county dss is aware of a SSI recipient who was terminated from SSI due to unreported income or resources, these are the steps that should be followed to determine if a Medicaid overpayment exist:

1. The caseworker completes the SSI ex-parte review and determines from the SDX that SSI was terminated for excess resources or income.

2. The caseworker must verify income and resources to determine eligibility for ongoing Medicaid. If it is determined that the client is not eligible for full Medicaid under any program or has a large deductible, the caseworker should establish whether the resources or income were newly acquired.

3. If resources or income are newly acquired, there is no referral for potential fraud. Examples:

   a. The caseworker verifies RSDI began the previous month.

   b. A client recently inherited $50,000.

4. If the client failed to report income or resources to SSI in a timely manner, there is a potential Medicaid overpayment. The case should be referred to the fraud unit for a possible overpayment recoupment.

   Example: The client interview or the verification of resources establishes that that client has $50,000 in CD at Wachovia and they were acquired several months ago.

5. If the county dss is aware that a SSI recipient has resources and that the resources make the recipient ineligible, the county dss should report this information to the Social Security Administration. Once SSA terminates SSI, the county dss should follow the guidelines I. 1-4 above.

6. These are other examples of when a case should be referred to the fraud unit for a possible overpayment recoupment:

(VIII.I.6.)

Example: A SSI client loans someone else his card and the other person receives benefits to which he was not entitled.

Example: The SSI client's Medicaid card may have been stolen and used by the thief.

Each of these situations would need to be investigated and a decision made as to whom the debtor would be for any benefits received fraudulently.

J. Medicaid Transportation Overpayments

Medical transportation overpayments occur when a recipient and/or provider of transportation requests transportation reimbursement for visits they never made to the Medical provider as claimed. To determine the overpayment for a Medicaid transportation claim, the investigator will need to take the following steps:

1. View county dss records of the dates for which the recipient claimed a need for reimbursement for transportation and reimbursement was given, either to the recipient, or the provider of transportation services.

2. Request a Medicaid/NCHC Recipient Profile for the dates of service in question. Compare the providers who billed Medicaid to the transportation reimbursement logs.

3. It may be necessary to contact the medical provider if there is no Medicaid claim on file as providers have at least 12 months from the date of service to file claims.

4. The overpayment will be the amount reimbursed the recipient and/or provider of transportation services for any dates medical services were not rendered to the recipient.

5. Enter the claim in EPICS as a Medicaid claim using the Medicaid case ID number and program code the recipient was receiving under at the time of the overpayment. The Medicaid service Code will be 71.

6. Depending on the circumstances, the debtor may be the recipient, the provider of transportation, or both.

IX. CONCLUSIONS AND RECOMMENDATIONS

A. Case Evaluation

The purpose of a full case evaluation is to review and organize all the data gathered during the investigation, to compare that data to all relevant regulations, policies and laws, and to weigh and prioritize the results. This leads to a decision as to the action to be taken on the case.

The county dss must use specific standards for prioritizing cases and apply them in the same way to all cases to ensure that individuals are treated equitably. The standards are set by the county dss in consultation with its local legal advisor. Consistency in application of these standards is imperative.

B. Responsibility of Overpayment

1. The investigator/caseworker must determine whether an existing overpayment is the result of fraud, recipient error or agency error.

2. If the overpayment was the result of an agency error, take immediate action to correct current eligibility. An overpayment that is the result of agency error is not be collected from the recipient.

3. If a recipient error occurred, take immediate action to correct ongoing eligibility.

4. If fraud or misrepresentation is suspected refer the case to a fraud investigator, giving all information obtained to date.

   NOTE: If the case remains the responsibility of the caseworker to determine fraud/abuse, the caseworker must follow all the steps outlined in this section and report the results.

C. Determining Who the Debtor Is

1. Debtors may include financially responsible adults, including parents of children, adult recipients and legal spouses of recipients, if they failed to report income and/or assets of any kind, or joined in the process of intentionally misrepresenting eligibility factors.

   a. Debtors may also be non-recipients, such as the applicant's representative, if they fail to report income and/or assets of the recipient.

   b. Other non-recipients may also be debtors if they use someone else are Medicaid ID Card to obtain benefits.

(IX.C.1.)

c. If the recipient "loaned " the Medicaid ID card to the non-recipient, they are co-debtors in the overpayment claim.

Example: The recipient may be a victim of theft. If someone steals a recipient's Medicaid card, and uses it to obtain Medicaid benefits, then the thief is considered the debtor. In this case the recipient would not be a debtor. However, if the recipient loaned the card to the non-recipient, then he is a co-debtor in the overpayment claim with the non-recipient

2. Under no circumstances would an individual who received benefits as a dependent child under age 18 be considered a debtor, even after the individual reaches age 18.

a. Determine how old the recipient was at the time of the overpayment and who the financially responsible adult(s) was during the overpayment period.

b. If a recipient is determined to be incompetent, he may not be considered a debtor, however, an overpayment may still exist. In this case, the representative, often the Power of Attorney may be found to be the debtor as the POA may be the person who benefited by the fraud/misrepresentation. Each situation should be evaluated based on its own merit.

3. Below are examples of who would be considered the financially responsible in certain cases.

a. LTC**:** The recipient and the community spouse are possible debtors. Often a LTC recipient is represented by someone else, and may not be aware of the rules. It is not unusual for the Representative to be the debtor, alone, or along with the recipient. If the representative benefited from the failure to report information, then they may be the only debtor, or a co-debtor. It would depend on the situation and on the competency of the recipient(s). Each case is unique in the factors that will decide whom the debtors are.

Example**:** A representative with Power of Attorney (POA) applies for LTC for their mother. They fail to report their mother's assets. During the application process the POA transfers all assets into their own name. In this case, the representative may be found to be the debtor. The reason for this is that the POA is the person who benefited from the fraud, or failure to report information. There may be a sanction for the recipient as well.

(IX.C.3.)

b. MAABD PLA: Legal Spouses who live in the home are financially responsible for one another under Medicaid regulations. In most cases both would be debtors. However, there may be extenuating circumstances, so look at each case individually.

c. PLA applicants/recipients may also have a representative apply for their benefits. If the representative knowingly misrepresents a recipient's income or resources, and it results in an overpayment, the representative may be considered a debtor.

Each case should be looked at individually based on in-depth interviews and a thorough investigation of the facts. If questions persist, contact your Medicaid Recipient Investigations Coordinator at 919 647-8000.

D. Guidelines for entering claims in EPICS when the case head is not the debtor or is not the only debtor.

1. Enter the claim into EPICS in the case head's name, since the claim must be tied to the correct case ID number and authorization period(s) for that program.

2. If the debtor is not a recipient and does not have an Individual ID Number, go into CNDS and create an ID Number for the non-recipient debtor. This may be done while entering a debtor in EPICS. See the EPICS User's Guide for instructions. Enter this person on the Debtor Detail screen as a debtor.

3. Enter as many debtors as appropriate; however, rarely will there be more than two debtors for a Medicaid claim.

E. Combining EIS Cases in EPICS

1. A case may have more than one Medicaid overpayment. Combine multiple overpayment periods for a case into one claim in EPICS as long as the overpayment periods are within the same EIS aid program category,(i.e., MAA, MPW) unless one of the overpayment periods is based on a court order and the other is not.

2. Use the case ID for the most recent overpayment period. Enter each overpayment period in the overpayment field on the claim detail screen. Refer to the EPICS User's Guide.

(IX.E.)

3. Do not combine NCHC or the Breast and Cervical Cancer coverage with any other Medicaid overpayments in EPICS. Establish a separate claim for each program in EPICS since each program has a separate funding source.

F. Investigative Summary

1. Complete the DMA-7058, Investigative Summary, upon completion of the investigation, detailing all factors causing the overpayment, the overpayment period, and amount of the overpayment.

2. The summary should contain recommended action based upon the investigator's knowledge of the situation. Weigh the merits of the alternatives for that case to determine the case objectives.

3. The overall objectives for any fraud investigation are punishment, restitution, deterrence, and the protection of society.

4. Present the completed summary to the County Board of Social Services or it's designee for a decision on whether to refer for prosecution, or to use administrative procedures for collection. Follow your county dss procedures.

5. All available options must be utilized to attempt collection on any debt owed to DMA.

G. Referral to County Board of Social Services

1. The County Board of Social Services or their designee is responsible for the review of the case circumstances and the final decision on whether to recommend referral for prosecution in accordance with state statutes.

2. The following factors must be given consideration:

   a. Was there a violation of policy?

   b. Was the violation of policy against the law?

   c. Were the elements of criminal action present?

   d. Did a recipient willfully and knowingly, with intent to deceive:

      (1) Make a false statement or representation,

      (2) Fail to disclose a material fact,

(IX.G.2.d.)

(3) And as a result, obtain, attempt to obtain or continued to receive Medicaid for himself or others?

e. Mitigating factors

(1) Prior/repeat offenses

(2) Recipient's physical and/or mental state

(3) Recommendation of County District Attorney

(4) Any other factors pertinent to the case such as the Statutes of Limitations

H. Guidelines for Criminal Prosecution

If the County Board of Social Services determines that a case should be referred for prosecution, there are several actions that will help ensure the case is disposed of justly.

1. Relationship with the Prosecuting Attorney

a. The county dss should establish a good working relationship with the district attorney or county attorney, whichever handles prosecution of fraud cases. The worker responsible for the case should ensure the attorney understands program requirements as they relate to the case. All case documentation should be provided to the attorney along with the investigative summary. The worker should be available to answer any questions that the attorney may have about any specific case or about program policies, procedures and regulations. Do not schedule court proceedings until all documentation is in hand.

b. The county dss should expect advice from the county/dss attorney on whether a case is a good one for prosecution, whether further evidence is required, and the type of information the attorney considers necessary for successful prosecution.

c. The attorney should be expected to help the agency in such areas as issuing warrants, appearing as a witness in court, etc.

d. Representatives from the county dss should meet with the attorney to discuss such a relationship. Only by discussing expectations will a worthwhile effort towards prosecution evolve.

(IX.H.)

2. Relationship with the Courts

    a. Take any opportunity that presents itself to speak with the judge who presides over prosecution of fraud cases in your county. Do not presume the judge needs to be educated in this area, but use the opportunity to introduce those people who will regularly appear in the court in the cases.

    b. While you cannot presume to tell the judge what sentence you wish rendered, you can inform the judge of certain program situations that may affect the sentence.

        (1) An example is the fact that providers have 12 months in which to file claims and the warrant may not reflect the total amount of the overpayment.

        (2) Another example is that CMS (the Center for Medicare and Medicaid Services) regulations do not allow for the compromise of Medicaid overpayment amounts.

    c. The judge may be able to advise you how to handle such situations. This does not suggest that you should meet with the judge or attempt to educate him on the law or influence his judgment in any way.

3. Relationship with Law Enforcement

    a. It is important to maintain a good relationship with the law enforcement branch that serves warrants in cases that have been referred for prosecution.

    b. Provide them with clear directions to the recipient's home, hours the recipient may be home and any other information that might expedite the serving of the warrant.

4. Appearing in Court

    a. When appearing in court in a possible fraud case, know the case thoroughly before taking the stand to testify. If you do not know the answer to a question, state you do not know. However, if the answer can be found in the record, state this fact and look in the record.

(IX.H.4.)

b. Only testimony from the case file should be given to avoid violating confidentiality and to avoid giving opinions. For this reason, the case summary should be a complete history of the investigation and should include all documentary evidence. Do not give opinions. If you have fully developed your case, everything you need will be contained in the investigative summary.

c. Answer all questions as concisely as possible. If you have to organize your thoughts before answering a question, do so. Do not rush into an answer that is not carefully thought out to avoid giving unnecessary or confusing information.

d. Remember the following:

(1) Prepare and present the evidence as a professional, do not get personally involved in a case.

(2) Always dress neatly and be well groomed.

(3) Never chew gum, avoid nervous habits. Assume a comfortable position.

(4) Be on time.

(5) Always be completely honest. Speak clearly, slowly and loudly enough to be heard.

(6) Address the judge as "Your Honor" in the courtroom. "Judge" is proper outside the courtroom.

(7) If a court official addresses you when you are not in the witness stand, it is proper to stand before answering.

(8) Stop your testimony immediately when there is an objection. Do not resume until the objection has been ruled on and you are instructed to continue or answer another question.

(9) If you need witnesses or materials to prove your case, be sure they are available.

(10) Call your witnesses the day before the court date to remind them of the time and place of the trial.

(IX.H.4.d.)

(11) If you are disappointed with the disposition of the case, do not let it show in court.

X. NOTICES & APPEALS

A. Notices

When a claim is established in EPICS the following occurs:

1. The DMA-8010, Notice of Overpayment for Medical Assistance, is generated for each debtor on the claim. The notice contains the initial overpayment amount and the period of ineligibility.

   a. The initial overpayment amount may change if additional claims are paid for medical expenses that were incurred during the period of ineligibility. The DMA-7059, Notice of Change in Overpayment for Medical Assistance, notifying each debtor of the change in the overpayment must be manually sent.

   b. The notice is produced in English. If you are aware that a debtor only reads Spanish, complete and mail the DMA 8010S to the debtor the same day the claims goes into CO status. File a copy of the manual DSS-8010S in the case record as documentation.

2. The notice is mailed the next business day after the claim is established. The date the notice is mailed is the date on the debtor detail screen on the Letter of Overissuance (LOI) field.

3. The DMA-8010 is mailed to the mailing address listed in EPICS for each debtor.

   a. If no address is listed for the debtor on the Debtor Detail screen, EPICS will send the DMA-8010 to the county dss address of the county responsible for the referral.

   b. When the DMA-8010 is returned to the county dss with no forwarding address, the Program Integrity Unit is responsible for searching all available sources for a mailing address and forwarding the notice to the debtor.

   c. If an address is located:

      (1) Update the notice mailing date, the mailing address, and the 60-day hearing date on the DMA-8010.

(X.A.3.c.)

(2) Forward the notice to the new address. File a copy of the revised notice in the case record and document the change.

d. If no alternate address is located, file the DMA-8010 and documentation of all sources searched for an address in the case record.

4. A report, FRD433 Letter of Overissuance, is produced daily. The report lists all debtors who were mailed a Notice of Overpayment. The report contains:

a. The debtor's name and ssn.

b. The EIS program code and Case ID.

c. The EPICS referral number.

d. The date the notice was mailed and the 60-day appeal date.

5. The notice instructs the debtor to contact the county Program Integrity Investigator to set up a voluntary repayment agreement if he has not previously made arrangements for full repayment of the debt.

B. Appeals

A client has the right to an appeal when benefits are modified or terminated. In the case of fraud/misinterpretation, the recipient may request an appeal of the corrected eligibility determination made during the investigation.

1. If a timely notice is sent and the client requests a hearing within the notice period, he may elect to continue to receive benefits until a decision is rendered from the initial hearing. See MA-2420, VI.A.9.a.

2. If the initial hearing decision upholds the county dss action, any benefits received by the client during the continuation of benefits period may be recovered by the state. The amount overpaid during this time should be added to any other verified overpayment when keying client responsible overpayments into EPICS.

3. The automated DMA-8010 "Notice of Overpayment for Medical Assistance" gives debtors sixty days to appeal the decision, or 90 days if they can show good cause for the delay. Follow the guidelines in MA-2420 for the Hearings process.

4. If a debtor requests an appeal of the overpayment within the 60-day appeal period, or 90 day period with good cause (Refer to MA-2420 IV.B for good cause definition):

(X.B.4.)

a. Send a request to the Medicaid Recipient Investigations Coordinator to enter an "H" in the NC Debt Setoff indicator field on the Debtor Detail screen in EPICS. This indicates there is a pending hearing, and will prevent a NC Tax Intercept until the hearing has been held, and a decision has been made.

b. Contact the DMA Recipient Investigations Coordinator to remove/change the indicator upon receiving the final hearing decision.

XI. ADMINISTRATIVE COLLECTION PROCEDURES

If the County Board of Social Services or its designee chooses not to refer the case for prosecution, the following options are available:

A. Voluntary Repayment Agreement

1. The recipient must indicate willingness to repay and will be given the opportunity to repay the overpayment in a lump sum payment or a specified amount on a monthly basis. Use the DMA-7060, Voluntary Repayment Agreement (VRA).

2. Always have the VRA notarized and keep a copy in the file. Send copies to Medicaid, and WF for their files.

3. When an individual misses the first payment of a VRA send a reminder letter. If a payment is not received within 30 days, take action to establish personal and/or telephone contact with the individual.

   a. If the individual continues to refuse to repay, consider small claims court, civil court action or the set-off debt collection process.

   b. In the case of the death of an individual with an outstanding debt, the county dss must file a claim against the deceased's estate for restitution.

   c. If the word "Seal" appears next to the recipient's signature, this will guarantee the investigator a longer period of collection. The civil statute of limitations for enforcement of collection is ten years from the date the VRA was signed. However, make sure the word "Seal" has been circled by the client. If further information is needed, contact your county attorney.

B. Voluntary Wage Withholding

1. Complete the DMA-7061, Voluntary Wage Withholding Agreement. Ensure that the wage withholding form has the word "Voluntary" on it and that all copies are notarized. Copies of the voluntary wage withholding form should be distributed as follows:

(XI.B.1.)

a. Send the employer a copy via certified mail.

b. Give the client a copy.

c. Keep a copy in your file.

d. Send copies to Medicaid, and WF and FS for their files.

NOTE: Always have the client sign a VRA as well as the Voluntary Wage Withholding agreement. Then, if the client quits a job, even though the voluntary wage withholding form is no longer valid, the agency still has the VRA.

C. Civil Court

1. Civil Court procedures are used solely for repayment. If the recipient is found liable, the court may enter a judgment against the recipient for the amount owed to DMA. Civil Court procedures may also be used when a recipient has failed to uphold a previously signed Voluntary Repayment Agreement. Consider the following factors:

   a. Proof of the overpayment amount

   b. Failure to repay the overpayment if a Voluntary Agreement was previously executed

   c. Court costs

   d. The likelihood of satisfying a judgment against the recipient given the allowable exemptions

2. Information is available through each county Clerk of Court on procedures to follow for this type of action. It is recommended that a determination be made as to whether Civil Court procedures would be cost effective to pursue restitution.

   Example: A recipient found guilty of felonious fraudulent misrepresentation by the Superior Court is ordered to pay $1,385, is given a suspended sentence of four years in prison, and is placed on four years probation. Payments received during the probationary period did not repay the entire amount owed and contact by the county dss with the probation office produced no results. When the order terminating probation was established, it was ordered that the arrearage be remitted. In this situation, civil action could be pursued to recover the amount owed. The county attorney may have to consult with the Attorney General's office.

(XI.)

D. Delinquent Accounts

Court Ordered Restitution - Upon notification of delinquent accounts, take the following actions:

1. Probation Office: For individuals who fail to comply with the terms of court ordered restitution and are on probation, contact the probation office to determine appropriate follow-up action, such as tax intercepts or wage garnishment. If the client is complying with his court obligation, assure that his taxes are not intercepted.

2. Clerk of Court: For individuals who fail to comply with the terms of court ordered restitution and are not on probation, contact the Clerk of Court to determine appropriate follow-up action, such as tax intercepts or wage garnishment. In some cases the Clerk of Court may issue an order for arrest for non-compliance.

   NOTE: Investigators are encouraged to seek permission from the Clerk of Court to issue non-compliance orders.

E. Estate Recovery for Deceased Debtors

1. A Medicaid overpayment can be recovered from a deceased debtor's estate when a recipient owes DMA for claims paid by Medicaid on the decedent's behalf, but for which he was ineligible. This is separate from Third Party Recovery claims on LTC cases.

2. If an overpayment is involved for a deceased debtor, the county dss should collect the overpayment amount first, as the county receives a greater incentive for overpayment collections, than for regular Third Party Estate recovery.

3. It is very possible to discover the overpayment upon the death of the recipient through verification with the Clerk of Court regarding the existence of assets of which the county dss was unaware. At the point the investigator verifies resources that created ineligibility for Medicaid a claim should be established in EPICS.

4. Request a Medicaid Profile via the DMA-7063 for the overpayment dates involved. Refer to section XVI., below, for instructions on how to determine the amount of ineligible claims that have been paid.

5. It is vital to complete the formal letter, "Notice and Presentation of Claim Against Estate." This letter must be completed and presented to the Clerk of Court and to the executor of the estate stating the amount of the overpayment. This establishes a claim against the estate on behalf of the county dss. Contact your local county Clerk of Court to obtain the letter.

(XI.)

F. Wage Garnishment

1. General Overview

   Wage Garnishment is a legal summons to withhold wages to satisfy a debt resulting from fraudulently receiving benefits from the Medicaid Program. North Carolina General Statute 108A.25.3 allows the garnishment of wages to recoup fraudulent public assistance benefits. This law applies to civil actions filed on or after December 1, 1997, regardless of the date the claim was established. A judge or jury in Criminal Court must determine the act of fraud. The garnishment process cannot be initiated to collect delinquent NCHC overpayments.

2. Wage Garnishment Criteria:

   a. The garnishment process cannot be initiated until all administrative collection methods are exhausted. The county must attempt to establish a cash repayment agreement. If the individual fails to meet the terms of the agreement, garnishment proceedings cannot be initiated until the account is 60 days delinquent. If the client makes a payment after the garnishment process begins, the garnishment procedure will continue.

   b. Garnishment is not an option if an individual is required to pay restitution for fraudulently receiving Medicaid benefits pursuant to a criminal court order. However, if the individual does not pay in accordance with the court order a separate civil action can be filed. This needs to be coordinated with the probation officer.

   c. The garnishment cannot exceed 20% of the monthly disposable income. Disposable income is defined as net income, wages, salary, commission, bonus, or other, or that which remains after any legally withheld deductions are made. Legally withheld deductions are those deductions required and not an option. These include Federal and State taxes, as well as Social Security. Retirement is also a required deduction with some employment.

   d. A civil judgement must be obtained against the individual prior to completing an order for garnishment. The amount due is the amount of the fraudulent benefits and any applicable court costs.

   e. The order for garnishment may be entered 10 calendar days after the judgment is filed with the Clerk of Court.

(XI.F.2.)

f. An order for garnishment may not be entered if the court finds that the order jeopardizes the individual's ability to become or remain financially self-sufficient, resulting in the likelihood of increased or recurring dependency on public assistance, or an inability to secure basic necessities.

g. The investigator will need to complete necessary budgets to determine if the garnishment would jeopardize the individual's ability to remain self-sufficient.

h. Once the fraudulent benefits and the costs of court are paid in full, it is the responsibility of the county agency to have the judgment removed at the Clerk of Court. The county must remove the judgment within 30 days of full repayment of the fraudulent benefits and the costs of court.

Note: The county investigator should obtain the North Carolina Rules of Civil Procedures from the Clerk of Court's Office if he does not already have one available.

3. Wage Garnishment Procedures

A judgment may be obtained after the civil court hearing is held or by default of the hearing. Default of the hearing occurs when the individual fails to appear for the hearing, or fails to make a plea regarding the matter. Once a judgment is entered, the county Department of Social Services may petition the district court for an order of garnishment. The "Petition for Order of Garnishment", must include the following:

a. Indication that the person is a former/current recipient.

b. An explanation of which public assistance programs are involved.

c. The amount of the fraudulent overpayment.

d. Circumstances surrounding the fraudulent benefit, and why it is fraudulent.

e. Information that all administrative means to collect the benefits have been exhausted unsuccessfully.

f. Verification that county dss has obtained a judgment. A copy must be attached to the petition.

g. The name and address of the garnishee.

(XI.F.3.)

h. The individual's verified monthly disposable income. Attempt to verify this through the employer or client. If this is not available, use Employment Security Commission information as last resort.

i. Verification that the proposed garnishment does not exceed 20% of the individual's monthly disposable income.

j. The Petition for an Order of Garnishment must be served on the individual, and on the garnishee usually the current employer of the individual.

4. Instructions For Completing Petition for Order of Garnishment

Note: Contact your local county Clerk of Court Office to obtain the "Petition for Order of Garnishment". Instructions are listed according to paragraph numbers in the Petition.

a. The petition may be brought by the county dss.

b. A district court judge in the county where the individual resides or is found, or in the county where the overpayment occurred may enter an Order for Garnishment. One of these situations must be alleged in the petition.

c. Orders for Garnishment may be obtained against individuals of public assistance. The petition must allege that the defendant is a past or current recipient. The allegation should explain that the Medicaid program is involved.

d. The petition must allege the amount of the fraudulent benefit(s).

e. The petition must provide the court with facts and circumstances surrounding the fraudulent benefit. The petition must allege how the benefit(s) is fraudulent.

f. The county dss is required to exhaust all administrative remedies prior to pursuing garnishment. The petition should state that all administrative means have been exhausted unsuccessfully.

g. The petition must indicate that the county dss has obtained a judgment for a sum certain against the individual. A copy of the judgment should be attached to the petition.

h. The Garnishee must be identified, and the garnishee's address must be given.

(XI.F.4.)

i. The petition must give the individual's monthly disposable income.

j. No more than twenty percent (20%) of the individual's monthly disposable income can be withheld. If the fraudulent benefit cannot be recovered in one payment, the petition must state the amount the county dss wishes to be withheld from the individual's monthly disposable income.

5. Time Restrictions for the Order of Garnishment

The service must be in accordance with Rule 4 of the North Carolina Rules of Civil Procedure, which states that upon the filing of the complaint, a summons shall be issued within five days.

a. The summons shall run in the name of the State and be dated and signed by the Clerk, Assistant Clerk, or Deputy Clerk in the county in which the action is commenced.

b. The complaint and summons shall be delivered to the sheriff of the county where service is to be made or to some other person duly authorized by law to serve summons.

c. Service must be made within 30 days after the issuance of the summons, and returned immediately to the issuing clerk who issued it with notation of service.

d. The individual and the garnishee have 30 days from the date of service to respond to the petition in accordance with Rule 12 of the Rules of Civil Procedure. A hearing date is set regarding the petition and is heard before a district court judge. Following the hearing the judge may or may not enter an Order for Garnishment.

e. The Order for Garnishment may be entered in the county where the individual resides, or is found, or in the county where the overpayment occurred.

f. If an order is entered, a copy must be served on the individual, as well as the garnishee. The order must be served personally or by certified mail, with return receipt requested.

g. The order must include sufficient findings of facts to support the action by the court and the amount to be garnished each pay period.

(XI.F.5.)

h. The amount to be garnished is based on the individual's verified monthly disposable income. The amount garnished each pay period may be increased by an additional $1.00, which is a processing fee, and retained by the garnishee (employer) for each payment under the order. The $1.00 processing fee is the responsibility of the garnishee.

i. The order shall be subject to review for modification and dissolution upon filing of a motion in the cause.

j. A certified letter is also mailed to the garnishee advising him of his responsibilities regarding the Order of Garnishment.

k. Upon receipt of the order of garnishment, the garnishee transmits without delay to the Clerk of Superior Court the amount ordered by the court to be garnished. The funds are disbursed to the county department of social services to recoup fraudulent benefits subject to the order of garnishment.

l. A garnishee that violates the terms of an order of garnishment shall be subject to punishment for contempt.

G. Liens and Recoveries

The county dss may place a lien against an individual's property, both personal and real, because of claims paid or to be paid on behalf of that individual following a court judgment which determined the benefits were incorrectly paid for that individual.

XII. BANKRUPTCY

A. General Overview

Generally bankruptcy means that a person has become unable to repay his debts in a timely manner due to a lack of funds in the foreseeable future. The debtor is seeking relief from all or part of his debt. According to a Supreme Court decision in 1934 this is the purpose of the bankruptcy law:

"It gives the honest but unfortunate debtor a new opportunity in life and a clear field for future effort, unhampered by the pressure and discouragement of preexisting debt."

(XII.A.)

Bankruptcy Law is federal statutory law, and can be found in Title 11 of the United States Code. Based on the U.S. Constitution, only Congress can regulate bankruptcy. The individual states can only pass laws that govern other aspects of the debtor-creditor relationship. Since the federal government governs bankruptcy law, bankruptcy proceedings are supervised and litigated in the U.S. Bankruptcy courts, which are part of the District Court system of the United States. These proceedings are governed by the Bankruptcy Rules set by the U.S. Supreme Court under the authority of Congress.

There are different chapters under which an individual or business may file for bankruptcy, with different rules governing each. The following information is meant as an overview for the Fraud Investigator. Please remember that each case is unique. The county investigator must research each situation as it occurs. This is important in order to insure the debtor pays as much of their debt to the county dss (creditor), as the law will allow. Once you learn a debtor has filed for bankruptcy, it may be necessary to call on the county attorney or the agency attorney for advice on how to approach the Medicaid overpayment.

B. Notification

The first order of business should be that the county dss is notified by the court that this debtor has filed for bankruptcy, and the county dss has been named as a creditor from whom the debtor is seeking relief, either partially or fully, through the Bankruptcy court.

The agency may hear about the bankruptcy, but never receive official notification. This could happen if the client failed to list dss as a creditor. In order to receive any distribution from the bankruptcy estate, the county generally will need to file a proof of claim with the Bankruptcy Administrator. The necessity and advisability of filing a proof of claim may require evaluation by an attorney.

C. The 341 Meeting

At some point each creditor is notified of the "341 meeting". Section 341 of the Bankruptcy Code requires a meeting be held at which the debtor(s) is questioned by the creditors. Depending upon the circumstances of the case, it might be advisable for a representative of the county dss to attend this meeting. DSS may learn there whether the debtor is seeking a full or partial discharge of the debt he owes. It is also a chance to hear what assets and disposable income this debtor is presenting to the court. The debtor is bound by law to be truthful, as concealing assets can lead to a dismissal of the Bankruptcy plan, if discovered at a later date.

(XII.)

D. How Bankruptcy Affects the Creditor

1. Bankruptcy is treated as a judgment and will stop most previous judgments. It also stops/prevents collectors/creditors from calling or contacting the party that filed the bankruptcy. Bankruptcy will be listed in credit reports for a period of up to 10 years.

2. If the court has already ordered restitution as part of a criminal conviction, this debt cannot be discharged through bankruptcy. The debtor will remain responsible for all of it. The county dss may continue to collect in every way as in the past.

3. Before the Bankruptcy Judge has confirmed a repayment plan, any creditor may object and seek full repayment according to certain specific exceptions to the bankruptcy discharge. There are time limits within which the objection must be made. This includes all creditors, even the county dss. However, the Bankruptcy Judge has the final say.

4. Take a close look at your case and take necessary steps to insure the county dss is not violating bankruptcy law. Once the county dss has been notified, or becomes aware the client has filed for bankruptcy, they should desist from collection efforts on all current claims. If a creditor continues efforts to collect they could face a stiff fine by the court. This includes tax intercept. Contact your State DMA Coordinator for assistance.

5. To prevent tax intercepts on a claim, send a request to DMA Recipient Investigations Coordinator to key an "L" in the Debt Setoff Indicator field for litigation. This includes wage garnishment or wage withholding. Make sure to contact the employer to stop these actions.

6. If the county dss establishes a new claim which arises AFTER a bankruptcy plan is already in effect, this new debt may not be governed by the Bankruptcy plan already in effect. It may be necessary to file an administrative claim in the bankruptcy proceeding in order to collect such debt, or it might be permissible to pursue collection outside of the bankruptcy proceeding. The advice of counsel may be necessary to assist with this evaluation.

   Exception: The client could request an Amendment to his Bankruptcy plan in order to add this new debt for discharge. Be aware that this could most likely happen in order to avoid tax intercept, or prosecution.

(XII.)

E. Types of Bankruptcy

1. **Chapter 7: Entitled Liquidation.** This is an orderly, court supervised procedure by which a trustee collects the assets of the debtor's estate, liquidates them, and distributes the proceeds to creditors. This is of course subject to certain rights of the debtor to retain exempt property and is also subject to the rights of secured creditors. Usually there are no assets in a Chapter 7. Also, under Chapter 7 a debtor can receive relief from dischargeable debts fairly quickly. He does not have to propose a repayment plan. For a creditor to receive anything from a Chapter 7 case, there needs to be assets, and the debtor must file a "proof of claim" with the bankruptcy court.

2. **Chapter 13: Entitled Adjustment of Debts of an Individual with Regular Income.** This is designed for those with regular source of income. It also may enable the debtor to keep a valuable asset such as a house. The debtor must propose a "plan" to repay his creditors over a period of time, usually three to five years, through a trustee. The plan must be based on the debtor's anticipated income. The majority of Bankruptcy filings for individuals and couples are done under Chapter 13.

3. **Chapter 11: Entitled Reorganization.** This is usually used by commercial enterprises in order to continue operating a business while repaying creditors through a court-approved plan of reorganization.

4. **Chapter 12: Entitled Adjustment of Debts of a Family Farmer with Regular Annual Income.** The difference between this and Chapter 13 is that it allows a family farmer to continue to operate his farm while the repayment plan is being carried out.

5. **Chapter 9: Entitled Adjustment of Debts of a Municipality.** This provides for reorganization just as chapter 11 does, except it is only for municipalities, which includes cities, towns, villages, counties, taxing districts, municipal utilities, and school districts.

F. Bankruptcy Terminology

Below you will find widely used terminology relating to Bankruptcy procedures.

Assume – An agreement to continue performing duties under a contract or lease.

(XII.F.)

Automatic Stay – An injunction that automatically stops lawsuits, foreclosure, garnishments, and all collection activity against the debtor the moment a bankruptcy petition is filed.

Bankruptcy Administrator – An officer of the judiciary serving in the judicial districts of Alabama and North Carolina who, like the United States trustee, is responsible for supervising the administration of bankruptcy cases, estates, and trustees, monitoring plans and disclosure statements, monitoring creditors' committees, monitoring fee applications, and performing other statutory duties.

Bankruptcy Estate – All legal or equitable interests of the debtor in property at the time of the bankruptcy filing. (The estate includes all property in which the debtor has an interest, even if it is owned or held by another person.)

Bankruptcy Petition – A formal request for the protection of the federal bankruptcy laws. (There is an official form for bankruptcy petitions.)

Claim – A creditor's assertion of a right to payment from a debtor or the debtor's property.

Complaint – The first or initiatory document in a lawsuit that notifies the court and the defendant of the grounds claimed by the plaintiff for an award of money or other relief against the defendant.

Confirmation – Approval of a plan of reorganization by a bankruptcy judge.

Creditor – A person to whom or business to which the debtor owes money, or that claims to be owed money, by the debtor.

Debtor – A person who has filed a petition for relief under the bankruptcy laws.

Discharge – A release of a debtor from personal liability for certain dischargeable debts. (A discharge releases a debtor from personal liability for certain debts known as dischargeable debts (defined below) and prevents the creditors owed those debts from taking any action against the debtor or the debtor's property to collect the debts. The discharge also prohibits creditors from communicating with the debtor regarding the debt, including telephone calls, letters, and personal contact.)

Equity – The value of a debtor's interest in property that remains after liens and other creditors' interests are considered.

Exempt Property – Property or value in property that a debtor is allowed to retain, free from the claims of creditors who do not have liens.

(XII.F.)

Fraudulent Transfer – A transfer of a debtor's property made with intent to defraud creditors or for which the debtor receives less than the transferred property's value.

Lien – A charge upon specific property designed to secure payment of a debt or performance of an obligation.

Liquidation – A sale of a debtor's property with the proceeds to be used for the benefit of creditors.

Liquidated Claim – A creditor's claim for a fixed amount of money.

Motion to Lift Automatic Stay – A request by a creditor to allow the creditor to take an action against a debtor or the debtor's property that would otherwise be prohibited by the automatic stay.

Non-dischargeable Debt – A debt that cannot be eliminated in bankruptcy.

Priority – The Bankruptcy Code's statutory ranking of unsecured claims that determines the order in which they will be paid if there is not enough money to pay all of them in full.

Proof of Claim – A written statement describing the reason a debtor owes a creditor money. (There is an official form for this purpose.)

Secured Creditor – An individual or business holding a claim against the debtor that is secured by a lien on property of the estate or is subject to a right of setoff.

Secured Debt – Debt backed by a mortgage, pledge of collateral, or other lien; debt for which the creditor has the right to pursue specific pledged property upon default.

Schedules – Lists submitted by the debtor along with the petition (or shortly thereafter) showing the debtor's assets, liabilities, and other financial information. (There are official forms a debtor must use.)

Trustee – The representative of the bankruptcy who exercises statutory power, principally for the benefit of the unsecured creditors, under general supervision of the court and the direct supervision of the United States trustee or Bankruptcy Administrator.

Unscheduled Debt – A debt that should have been listed by a debtor in the schedules filed with the court, but was not. Depending on the circumstances, an unscheduled debt may or may not be discharged.

XIII. DISTRIBUTION OF CASH REPAYMENT

A. State law requires that in cases involving overpayments in more than one program, collections must be distributed equitably. This should be followed unless the debtor asks that a payment be applied to a particular claim.

B. It is important that the investigator or collections clerk explain to the debtor that failure to distribute payments among all their claims could cause a claim to become delinquent. If a claim in EPICS is delinquent the debtor's North Carolina tax refund will be intercepted and applied toward the overpayment claim in EPICS.

XIV. EPICS REPORTING REQUIREMENTS

DMA Quality Assurance is responsible for the administration of the Medicaid recipient investigations conducted by the county departments of social services. To comply with state and federal reporting requirements, each county is responsible for entering all fraud and client responsible overpayment claims into EPICS. Refer to the EPICS User's Guide for system instructions.

A. County Incentive Payments

In an effort to offset county administrative costs for program integrity activities and staff and provide cost savings through increased investigation and collection of Medicaid overpayments, the Division of Medical Assistance implemented a county incentives program for collections of client responsible overpayments effective February 1, 1997.

1. The county departments of social services receive monthly incentive payments from the Division of Medical Assistance based on collections for recipient responsible overpayments.

2. The calculation for county incentive payments is based on one-half of the non-federal share of county collections for client responsible medical assistance overpayments.

3. The county, state, and federal reimbursement rates vary slightly from year to year. The county incentive is based on the actual state and county reimbursement rates that were in effect during the overpayment period captured in EPICS.

4. Incentive payments are based on collections keyed into EPICS. Collections are passed from EPICS to the Medicaid Accounting System and incentive payments are credited back to the county through the monthly Medicaid Adjustment Register.

(XIV.)

B. State law requires the following actions regarding reporting the status of fraud/overpayment cases:

1. The county dss must provide a detailed report on each case that is initiated or investigated. This report must be provided within 6 months from the date the Medicaid/NCHC Recipient Profile is requested. EPICS is designated for this function.

2. Data on EPICS claims are accessible in reports generated in NCXPTR, as claims are entered and funds collected in EPICS. See the EPICS User's Guide for a list of reports accessible to the county dss.

XV. NC DEBT SETOFF (TAX INTERCEPT) CRITERIA FOR MEDICAID CLAIMS

A. Background

1. The purpose of this section is to explain the procedures for North Carolina Debt Setoff Collection for Medicaid through EPICS. North Carolina General Statute 105A establishes a policy that allows the Department of Health and Human Services (DHHS) to identify debtors who owe money to the Medicaid, Work First and/or Food Stamp programs as the result of IPV or IHE. This Statute allows DHHS agencies to collect the debt by intercepting income tax refunds through the North Carolina Department of Revenue (DOR).

2. General Statute 105A-12 requires programs within State agencies to register with DOR before they can participate in the NC Debt Setoff Collection Act. DOR then assigns an "Agency Code" to each program type on the date they register. Therefore, each program has priority for tax intercept based on the date each program registered with DOR. If a debtor who meets the criteria to have his taxes intercepted has claims in multiple DHHS programs that are submitted to DOR at the same time, the intercept of the tax refund is applied in the following order for each program type:

Child Support	Non-EPICS
Medicaid	TPR (non-EPICS)
Food and Nutrition Services	EPICS
Work First/AFDC	EPICS
Medicaid/NC Health Choice	EPICS

(XV.A.2.)

Note**:** The Division of Medical Assistance applied for a second agency code for Medicaid since debtors are submitted to DOR separately for EPICS and TPR. Since 80% of Medicaid's tax intercepts are for TPR Medicaid, EPICS Medicaid was assigned the newest DOR agency code.

B. NC Debt Setoff Process in EPICS

1. The EPICS NC Debt Setoff process consists of three phases from the time of selection of eligible debtors until a tax refund is intercepted and the payment applied in EPICS. The PI Investigator needs to maintain the data in EPICS to ensure debtors are not inappropriately selected for debt setoff.

   a. The selection process for NC Debt Setoff is evaluated separately for each program type: Medicaid, Food and Nutrition Services and TANF/AFDC.

   b. The entire process takes approximately seven weeks from start to finish.

   c. A new selection cycle starts each week as all claims in EPICS are evaluated to determine if they meet the criteria for the debtor to be selected and submitted to DOR for possible tax intercept.

2. The three phases of the NC Debt Setoff process are:

   Phase I - Selection of Eligible Claim Debtors and Submission of Files to DOR
   Phase II - Tax Intercept and Notice to Debtor
   Phase III - Application of Payments in EPICS and/or Refunds to Debtors

C. Phase I - Selection Of Debtors And Submission Of Files To DOR

1. Each Medicaid claim is evaluated separately to determine if it meets the criteria for selection for NC Debt Setoff for Medicaid. To be selected a debtor's claim(s) must meet the following criteria:

   a. The debtor must have a ssn (non-duplicated) in EPICS/CNDS.

      Note: In the event a debtor is found to have the same ssn as a different person in CNDS, then the debtor will be rejected from the NC Debt Setoff selection process.

   b. The claim must be in Collection (CO) or Terminated (TE) status.

(XV.C.1.)

c. The claim type must be IPV or IHE.

d. The claim must be delinquent. A claim is delinquent when the following conditions are met:

(1) The claim Establishment Date, located on the Claim Detail Screen, must be greater than 60 days old. This calculation is made at the time the NC Debt Setoff Selection process runs using the 'current date' for comparison.

(2) No cash payments have been made on the claim in more than 60 days.

e. The total current claim balance for the debtor's eligible claim(s) must be at least $50.

(1) If a debtor has one Medicaid claim, the claim balance must be at least $50, or

(2) If a debtor has two or more Medicaid claims that meet all of the criteria for selection, then the total current balance for all eligible claims are combined into one amount and the total combined amount must be $50 or greater.

2. The criteria listed above are evaluated for each program type and for each claim separately. This means that the debtor may have multiple claims within a program type, such as Medicaid, but some of the claims may not meet the criteria for intercept. The debtor may also have claims for more than one program type (i.e., Medicaid and Food and Nutrition Services) but only claims for one program type may meet the criteria for intercept. It is possible for a debtor to be submitted for intercept for all three program types at the same time.

3. Claims are evaluated every week to determine whether a debtor’s claim(s) meet all of the criteria for the debtor to be selected for submission to DOR for possible intercept. This process means debtors are constantly being submitted to DOR for possible intercept of any refund due the debtor.

4. Debtors are submitted to DOR based on the debtor's social security number that exists in EPICS.

Note: If a debtor does not have a valid ssn in EPICS/CNDS, the debtor cannot be submitted for tax intercept. In addition, if an invalid ssn is in EPICS/CNDS, it is possible that a tax refund of another individual will be incorrectly intercepted.

(XV.)

D. Phase II – Tax Intercept And 30 Day Notice To Debtor (DSS-8653)

Once the tax intercept has occurred, DOR will forward a file to EPICS for each program type with the individual debtor information for each successful intercept and the dollar amount that was intercepted for each debtor.

1. The Notice to Debtor, DSS-8653, is mailed to the debtor's DOR mailing address since this is the address the debtor provided DOR for receipt of their tax refund. This address is reflected on the NC Debt Setoff 30-Day Notice Report.

   a. If the notice is returned to the county by the postal service, forward the notice to the mailing address shown in the county's file, if different.

   b. If the notice cannot be successfully delivered by the postal service, file the returned notice in the case record.

   c. The intercept will be processed since the notice was sent to the best available address known to DOR and the agency.

   d. DOR notifies the debtor that their tax refund has been intercepted, in whole or in part, using the same address.

2. Content of Notice to Debtor

   a. The Notice to Debtor explains the agency's basis for the claim to the debtor's NC tax refund and the intent to apply the refund against the Medicaid, Food Stamp, and/or TANF/AFDC debt(s) owed to the county department of social services.

   b. The Notice informs the debtor of his right to contest the tax intercept by filing a written Petition for a hearing with the Office of Administrative Hearings (OAH) within 30 calendar days from the date of the Notice to Debtor.

      (1) General Statute 105A-8 specifies that the debtor cannot contest the action if the debt has been previously litigated in a court proceeding.

      (2) Refer to XV.E., below, for the specific criteria for debtors appealing the intercept.

   c. The notice specifies that failure to request a hearing by the 30th day results in setoff of the claim(s) with the intercepted tax refund.

(XV.D.2.)

d. The notice includes the debtor's social security number as it exists in EPICS/CNDS, the debtor's name and the mailing address provided by DOR.

   Note: This information, including the DOR address, as well as the programs that received the intercepts, are provided on the FRD431 - NC Debt Setoff 30-Day Notice Report.

e. The notice reports the current balance owed for the outstanding claim(s) that meets the requirements for NC Debt Setoff for Food and Nutrition Services, AFDC/TANF, and/or Medicaid that is successfully intercepted. The totals shown are not the amount that is intercepted, but the amount of the eligible claim balance(s) owed to each program that was intercepted.

   (1) The amount owed is shown for each program type, as well as, the combined total amount owed if the debtor has eligible claims for more than one program type that is successfully intercepted.

   Example: The debtor has eligible delinquent claims for TANF of $200 and Medicaid of $3,000. The tax refund that is intercepted is $500. The Notice will show the $200 amount for TANF and the $3,000 amount for Medicaid since the tax refund was large enough to intercept an amount for both programs.

   (2) Only claim balances for the program type that is successfully intercepted is printed on the Notice to Debtor and the FRD431 - NC Debt Setoff 30-Day Notice Report.

   Example: The debtor has eligible delinquent claims for Food and Nutrition Services of $200 and Medicaid of $600. The tax refund that is intercepted is $100. The Notice will not show the $600 amount for Medicaid since the tax refund was not large enough to intercept an amount for the Medicaid claim.

   (3) Claims that do not meet the requirements for debt setoff are not included in the totals; therefore, the debtor's actual debt for the program type may be more than is reflected on this notice.

   (4) The debtor is informed to contact the Program Integrity Section at the county department of social services listed on the notice if he has questions concerning the intended action.

(XV.D.)

3. Multiple Notices

   a. It is possible for a debtor to receive multiple copies of the Notice to Debtor if he has eligible claims in different counties that are successfully intercepted.

   b. Each notice will provide the debtor with the county name, address and telephone number for the county with ownership for the claim(s) shown on the notice.

   c. The 'balance eligible for intercept' for each program shown on the Notice is the cumulated balance(s) for the eligible claims for that county only. It is possible for the cumulated balance shown for each program type to be less than $50 when there are multiple claims in different counties for the same program type.

      Example: The debtor has eligible Medicaid claims of $30 in County A and $35 in County B that was successfully intercepted. Although the amounts shown on the notice for each county is less than $50, the combined total of the two claims is greater than $50.

   d. The NC Debt Setoff 30-Day Notice Report shows if the debtor has eligible claims that were successfully intercepted in multiple counties. Refer to d., below, for detailed information about this report.

4. 30 Day Notice Report FRD431

   The NC Debt Setoff 30-Day Notice Report FRD431 lists the debtors whose taxes were successfully intercepted and were mailed the 30-Day Notice to Debtor. The report is produced for each Investigator within the county. The report is also a useful tool for answering questions from a debtor.

E. Appeal Requests

1. Appeal Requirements

   a. The debtor has 30 calendar days from the date of the Notice to Debtor to request a hearing to contest the tax intercept.

   b. The debtor must request a hearing by filing a written petition with the Office of Administrative Hearings and meet all of the following requirements.

      (1) The request for a hearing must be mailed with postage prepaid and properly addressed or delivered by the 30th day after the date on the notice.

(XV.E.1.b.)

(2) The debtor must mail or deliver the original and one copy of the petition requesting the hearing to the Office of Administrative hearings at the following address:

Mailing Address:	Physical Address:
Office of Administrative Hearings	Office of Administrative Hearings
6714 Mail Service Center	1711 New Hope Church Road
Raleigh, NC 27699-6714	Raleigh, North Carolina 27604
(919) 431-3000	(919) 431-3000

(3) The debtor must also mail or deliver a copy of the petition to the agency named as the respondent on the petition, which is the DHHS, listed on the Notice to Debtor.

(4) If the debtor does not request a hearing by the 30th day, the debtor has waived the opportunity to contest the action and the intercepted amount of the tax refund will be applied to the claim that is owed to county department of social services on the 35th day.

c. If the debtor waives his right to a hearing, send a request to the DMA Recipient Investigations Coordinator to enter the NC Tax Appeal Indicator code of 'W' on the "NC Debt Setoff Pending Intercepts" screen. Document the request on the EPICS Notepad. EPICS will process the payment immediately.

Note: The debtor may wish to waive his right to the appeal if he agrees with the intercept and his current outstanding balance is less than the intercepted amount since EPICS will immediately process the payment and refund due to the debtor. This can occur if a payment was made to reduce or pay off the claim after it was submitted to DOR for the intercept.

2. Debtor Calls DSS to Request a Hearing

a. If the debtor wants to contest the tax intercept, the debtor must request a hearing through the Office of Administrative Hearings (OAH) by filing a petition for a hearing.

b. Advise the debtor to contact OAH at the address or telephone number shown above or shown on the Notice to Debtor the received. OAH will provide the debtor with information regarding the specific requirements to request a hearing.

c. The debtor is required to file an original and one copy of the petition with OAH and a copy must be served on the opposing party, which is the county department of social services.

d. See the "Petition for a Contested Case Hearing" and the OAH instructions for completing the form.

(XV.E.2.)

e. Additional information regarding the Office of Administrative Hearings is available at: http://www.oah.state.nc.us/hearings.

3. Debtor Files a Petition For a Hearing

a. If the debtor files a petition for a hearing, the DMA Recipient Investigations Coordinator will enter an 'R' in the NC Tax Appeal Indicator field on the "NC Debt Setoff Pending Intercepts" screen upon receiving notification from the county or the Attorney General's office. An entry will be made by the 35th day from the date of the Notice to Debtor if notification is received timely.

Important Note: If the appeal indicator is not keyed into EPICS by the 35th day, the intercepted amount will be applied as a payment against the eligible claim(s).

(1) When the value of "R"' is present in this field, a payment/refund cannot occur as the debtor is still in the "Request Appeal" stage of the appeal.

(2) The code will remain unchanged until the county Investigator sends a written request to the Recipient Investigations Coordinator to update the code when the hearing decision is reached.

(3) If the appeal is in favor of the debtor, it is important to update the Appeal Indicator code immediately as interest is accruing for every day the money is held until the intercepted funds are refunded to the debtor.

b. The valid Appeal Indicator codes for the NC Debt Setoff Pending Intercepts screen are as follows:

W	Waived Right to Hearing. EPICS will process payment(s) immediately after the DMA Recipient Investigations Coordinator receives a request to key the "W" code.
R	Request for an Appeal by Debtor. EPICS will not process payment(s) regardless of the time elapsed since the 30-Day Notice to Debtor was mailed once a request is sent to have the DMA Recipient Investigations Coordinator key the "R" code.
N	Appeal Denied In Favor of the State/County. EPICS will process payment(s) immediately after the Recipient Investigations Coordinator receives a request to key the "N" code.
Y	Appeal in Favor of Debtor. EPICS will not process payment. The DHHS Controllers Office will immediately issue a refund to the debtor for the amount intercepted by DOR (plus any interest accrued and possible collections fee). Note: The Investigator must send a request to the Recipient Investigations Coordinator to reset the "Y" code once the Controllers Office issues the refund to the debtor. The county Investigator must document the request on the EPICS Notepad.
O	"Other" – to be used when the intercept should have been blocked due to reasons other than those above. EPICS will issue an immediate refund.

(XV.E.)

4. Hearing Decision Reached

   a. Once a hearing decision is reached by OAH, immediately send a request to the DMA Recipient Investigations Coordinator to update the Appeal Indicator code with 'Y' or 'N' on the NC Debt Setoff Pending Intercepts screen depending upon the hearing decision. Request the appropriate code as listed in B., above.

   b. If the hearing decision is in favor of the county (code "'N"), EPICS will process the payment/refund immediately and the appeal indicator will automatically be reset to "space". This will allow any claims with an outstanding balance to be evaluated for future NC Debt Setoff selections.

   c. If the hearing decision is in favor of the debtor (code "Y"), the DHHS Controllers Office will immediately issue a manual refund to the debtor, plus any interest accrued and possible collections fee.

      (1) Since no payment is credited through EPICS, the "Y" value will remain on the NC Debt Setoff Pending Intercepts screen until the Investigator requests the DMA Recipient Investigations Coordinator remove it.

      (2) Any debtor that has a "Y" in the Appeal Indicator will not be eligible for DOR selection until the Investigator requests the DMA Recipient Investigations Coordinator change the "Y" to a space. The debtor will appear on the "Claims Exempt from NC Debt Setoff Report" (FRD429) until the "Y" is deleted.

F. Phase III - Application of Payments in EPICS and Refunds

1. Schedule for Applying Payments

   The apply payment process will run every business night searching for any intercepts that are eligible to be applied to claim balances. This will occur when the appeal process has completed. This process will occur after the 35th day if no appeal is requested, when the code to waive the appeal rights is entered into EPICS, or when the hearing decision code is entered into EPICS.

2. How Payments Are Applied

   a. EPICS receives 3 files from DOR, one for each program type: Medicaid, Food and Nutrition Services and Work First/AFDC. Once the appeal process has been fulfilled, EPICS applies the payment across all eligible claims that were initially selected for submission to DOR for each program type that has an intercept.

(XV.F.2.a.)

(1) DOR intercepts money for one program type at a time for any given debtor's ssn based on the program's priority number.

(2) If the tax refund available to be intercepted from DOR is larger than the debt owed for the eligible claims for a single program type, then EPICS can potentially receive an intercept for all three program types for any given debtor.

Example: Amount available for intercept is $1,000. The debtor has eligible claims submitted to DOR for FS for $400, WF for $200 and MA for $700. The first intercept is for FS. Since there is $600 still available for intercept, the next intercept is for WF. Since $400 remains to be intercepted, the next intercept is for MA. If the claim balances remain the same at the time the payments are applied in EPICS, the FS and WF claims will each be paid in full. The current balance for the MA claim will be reduced to $300.

(3) If the amount intercepted from DOR is for eligible claims for one program type only, then no portion of the amount can be applied to any additional claims for that program or to the claims for any other program type.

Example: If an amount is intercepted for the Medicaid program and a portion of the refund must be refunded to the debtor, this excess amount cannot be applied to any additional Medicaid claims that were not eligible to be submitted for tax intercept. In addition, it cannot be applied to any Food Stamp or Work First claims. The excess amount must be refunded to the debtor.

b. The intercepted amount can be applied to one or more claims within a program type, provided the claims were originally selected for NC Debt Setoff.

(1) When the payment for the intercepted amount is applied, the payment will be applied to the oldest claim first based on the Establishment Date of the claim.

(2) The balance of the intercepted amount will be applied to the remaining claims based on the Establishment Date for each claim.

(3) If there are two or more claims with the same Establishment Date, the payment will be randomly applied to one or more of the claims.

(XV.F.2.)

c. If the claim is paid in full by the intercepted funds, the claim/referral is closed in EPICS.

d. If the claim is not paid in full, the outstanding balance is reduced by the payment amount.

e. The method of payment for all NC Debt Setoff payments is recorded as an "N" and is seen on the Payment History by referral and Payment History by Individual ID screens.

3. NC Debt Setoff Indicators and the Appeal Indicators

a. After the intercepted amount has been applied, refunded or both, all of the claims that were included in that particular intercept will have their NC Debt Setoff Indicator, located on the Debtor Detail screen, set from “D” back to a blank space by EPICS.

b. The Appeal Indicator, located on the NC Debt Setoff Pending Intercepts screen, will be reset to a blank space by EPICS once the intercepted amount has been applied, refunded to the debtor or both, except when the Appeal Indicator is set to “Y”. The Investigator must send a request to the DMA Recipient Investigations Coordinator to reset the 'Y' indicator after the refund is made to the debtor. Document the request on the EPICS Notepad. (Refer to E.4.a., above.)

c. The claim is reset to a blank space to allow the unpaid claims with an outstanding balance to be evaluated for future DOR selection.

4. Refunds to Debtors

a. The DHHS Controllers Office will mail NC Debt Setoff refunds to the debtor. The refund checks will be written twice weekly, on Tuesday and Friday. All refunds will appear on the FRD107, NC DEBT FIN RFD report. This report shows the amount that is to be sent to the debtor for DOR over collections, as well as the date the refund check will be written. Checks are written weekly by the Controller’s Office.

b. If the tax intercept amount exceeds the total amount owed by the debtor for the program type at the time the payment is applied to the eligible claim(s), the remainder of the intercepted amount must be refunded to the debtor. This will not occur unless a payment is made on the claim after it is submitted to DOR for intercept.

(XV.F.4.)

c. If the status of the debtor's claim(s) changes after the claim is selected for intercept and submitted to DOR, the payment will still be applied to the selected claims if there is an outstanding balance.

(1) If the intercepted amount is greater than the amount of the debt at the time the payment is applied to the claim(s), the over-collected amount, as well as accrued interest, will be refunded to the debtor.

(2) The collection fee will not be refunded to the debtor.

d. There are exceptions that may come about between the time the debtor was intercepted by DOR and the time the application of payment actually occurs. These exceptions will appear on the Exception Log Report received by the State for further investigation. They include:

(1) The debtor has been deleted.

(2) The claim changes to Closed Status, "CL" (i.e. Balance gets paid off).

(3) The claim changes to some other status (i.e. Transfer Status, "TR").

G. Reports for NC Debt Setoff

There are several reports available in NCXPTR that track claims as the debtors are selected for intercept of their North Carolina tax refunds. A detailed description of each report can be found in Appendix F of the EPICS manual. Relevant reports include the following:

1. Claim Debtors Exempt From NC Debt Setoff Report (FRD429)

2. Claims Selected For NC Debt Setoff Report (FRD213)

3. The NC Debt Setoff 30-Day Notice Report (FRD431)

H. NC Education Lottery Interceptions

The NC Lottery Interception (NCEL) process intercepts lottery winning to repay IPV and IHE claims. Lottery winnings must be at least $600.00 for an interception to take place. NCEL uses the same rules for selecting eligible debtors as DOR. It also applies the interception in the same order as the DOR intercepts. Intercept requirements:

(XV.H.)

1. DHHS provides a file to NCEL each week. Each weekly file replaces the previous week's files. It reflects EPICS latest claim balances and drops or adds claims depending on the current balance and selection criteria.

2. NCEL provides a file to DHHS as money is intercepted. EPICS sends a notice, DSS 8234, to the debtor regarding the interception and the claim balance.

3. The debtor does not have recourse for a hearing or appeal regarding the NCEL interception.

XVI. NORTH CAROLINA TITLE XIX MEDICAID RECIPIENT/NCHC PROFILES

A. Purpose of the Recipient Profiles

The Medicaid/NCHC Recipient Profile provides detailed claim information of medical expenses and services Medicaid paid for an authorized recipient. Request a Recipient Profile to determine the amount ineligible claims.

B. Requesting a Recipient Profile

1. Upon determining the period of ineligibility, request a Recipient Profile for each ineligible recipient to determine the amount of medical claims Medicaid paid.

   a. Complete a DMA-7063, Recipient Request Sheet for each EIS case. The form can be located on-line at http://www.dhhs.state.nc.us/dma/formsqa.html

   b. Instructions for completing the DMA-7063 are located on the back side of form. Mail or fax the completed DMA-7063 to:

      Division of Medical Assistance
      Quality Assurance Section - 18
      2501 Mail Service Center
      Raleigh, NC 27699-2501

      Fax 919-715-7706

   c. Profiles are normally returned within 3 weeks of request. If not received within 3 weeks of the original request, re-fax the original DMA-7063 and write "2nd Request" in bold on the form.

(XVI.B.)

2. Requests for Recipient Profiles for Overpayments due to Transfer of Assets Sanction

   a. Complete the DMA-7063 form to request the Recipient Profile. Ensure that you check the "yes" box by the question, "Is the period of ineligibility due to a transfer of assets sanction?" You must also check the box to indicate the client's living arrangement, whether LTC, PLA or CAP.

   b. The Recipient Investigations Coordinator orders the profiles from EDS. When DMA receives the profiles, the Coordinator reviews them to determine which claims were non-covered during the sanction. The Coordinator then prepares a letter for the investigator, detailing the amount of the non-covered claims to be included in the overpayment. Refer to section VIII.D. for the steps to follow to compute an overpayment due to transfer of assets.

3. Request for Recipient Profile for the Family Planning Waiver (FPW)

   a. When the recipient is not eligible for Medicaid under other program categories and the investigator determines that the recipient is eligible for FPW, and the recipient indicates that he/she has used FPW services, the investigator must request profiles for the FPW.

      (1) To request profiles for the FPW check the "yes" box by the question, "Is this request for Family Planning Waiver profiles?

      (2) Below (Dates of Service) box, check "FPW" and indicate the from and through dates for these services.

   b. The Recipient Investigations Coordinator orders the profiles from EDS. When DMA receives the profiles, the Coordinator reviews them to determine which claims are for FPW related services. The Coordinator prepares a letter to advise the investigator of the total amount for FPW claims. The amount of FPW claims must be deducted from the total overpayment amount.

4. Recipient Profile Request to Expedite Overpayments due to Excess Reserve.

   a. When termination is proposed for an authorized case due to excess reserve, it is critical that the investigator quickly verify any prior months of ineligibility and, if there is a period of ineligibility, to quickly establish the overpayment amount before the recipient reduces reserve on other expenditures.

(XVI.B.4.)

b. Paid claims information is available on-line to DMA for the past 18 months of history

c. Fax or telephone (919) 647-8000 the Recipient Investigations Coordinator to verify the current amount of paid claims reflected on-line for the overpayment period. Claim information cannot be requested for on-line information unless a claim is established in EPICS for excess reserve and meets the following criteria:

(1) Termination is proposed due to excess reserve and the Investigator verifies there is a period of ineligibility for the time the recipient was authorized within the past 18 months.

(2) The Investigator needs to notify the client of the approximate overpayment amount before the client reduces reserve by spending it elsewhere.

d. All telephone requests must be followed up by a written request on a DMA-7063 mailed or faxed to the DMA Quality Assurance Section.

Example: The IMC verifies from the FRR that a LTC recipient is over reserve by $8,000 due to unreported assets. Timely notice is sent to propose termination for ongoing coverage. It is also verified that the recipient was ineligible for Medicaid for the prior five months of authorization due to excess reserve. There is a Medicaid overpayment if claims for medical expenses were paid during the period of ineligibility. The Investigator contacts DMA by telephone and quickly establishes $9,870 in claims paid to date for the period of ineligibility. The recipient is able to reduce reserve for ongoing coverage by paying the overpayment amount. If the recipient quickly spends the excess reserve for other purposes to avoid case termination, there may be no funds left with which to repay the overpayment.

5. Recipient Profile Request for MQB-B or MQB-E are not Necessary

a. The only payments for MQB-B, MQB-E, MQB-Q recipients are the Medicare Part B premiums. The overpayments for these claims are determined by totaling the Medicare premiums paid by DMA for those recipients during the period of ineligibility.

b. Refer to the History of Medicare Deductibles, Co-Payments and Premiums for the current and archived Medicare premiums.

(XVI.)

C. Request for Recipient Profiles other than to Collect Overpayments

1. Guardian Ad Litem or GAL

The guardian ad litem or GAL, has the authority per **NC G.S. 7B-601** to "obtain any information or reports, whether or not confidential, that may in the guardian ad litem's opinion be relevant to the case. No privilege other than the attorney-client privilege may be invoked to prevent the guardian ad litem and the court from obtaining such information. The confidentiality of the information or reports shall be respected by the guardian ad litem and no disclosure of any information or reports shall be made to anyone except by order of the Court or unless otherwise provided by law."

To insure confidentiality, the GAL should send an original "True Copy" of the GAL court order, the "Order to Appoint or Release Guardian Ad Litem and Attorney Advocate", to the attention of your state Recipient Investigations Coordinator at DMA Quality Assurance, 2501 Mail Service – 18, Center - Raleigh, N.C. 27699-2501. Accompanying the GAL court order should be a letter from the GAL or the Attorney Advocate, specifically including the following:

a. The names of the recipients for whom Medicaid records are needed, along with their Medicaid ID number and social security number. Without these DMA QA will not be able to process the request.

b. The dates of service needed.

c. Signature of GAL, along with a business phone number at which he can be reached.

d. Once the profiles are received by DMA, they should be sent by certified mail to the GAL at the court in which he serves or hand delivered requiring proof of identity upon delivery.

2. Social Workers

Social workers may ask the fraud investigator to order profiles for reasons other than for those allowed under confidentiality guidelines. These requests usually come from Protective Services Workers who may need the medical records to use in court to show neglect or abuse. To order these profiles:

(XVI.C.2.)

a. The social worker must complete form DMA-7098, County Authorization to Disclose Information. The form can be located on-line at http://www.dhhs.state.nc.us/dma/formsqa.html. The county dss director or his designee must sign the form.

b. Mail or fax on county letterhead, the completed DMA-7098, County Authorization to Disclose Information form to:

Division of Medical Assistance
Quality Assurance Section - 18
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax 919-715-7706

3. Recipients

When a recipient requests profiles, the request can be process in one of two ways:

a. Advise the recipient or his legal representative to contact DMA Program Integrity Quality Assurance Section at (919) 647-8000, or

b. The county dss may order the recipient's profile. Instruct the recipient or authorized representative to complete and sign the DMA-7097, Recipient Authorization to Disclose Health Information form. The form can be located on-line at http://www.dhhs.state.nc.us/dma/formsqa.html. Fax on county letterhead, the completed form to (919) 715-7706.

c. DMA will forward the Medicaid/NCHC Recipient Profile to the county dss. The county dss should contact the client to inform him that the profiles are available. The client or his authorized representative must physically pick up the profiles.

d. Prior to releasing records, require proof of identity from the client or legal representative.

e. If the client or his authorized representative does not pick up the profiles within 30 days from the day of contact, shred the profiles.

4. Law Enforcement

Local Law Enforcement officers may ask the fraud investigator for a recipient's medical information for an investigation. In most cases, medical information may not be released without a court order. Refer these calls DMA Program Integrity at (919) 674-8000.

(XVI.C.)

5. Attorneys

   Attorneys may contact a dss investigator to obtain information on medical claims Medicaid paid on behalf of a recipient. Refer the attorney to DMA's Third Party at (919) 647-8100.

6. Other Request

   If you get other requests for profiles and this section does not address how to handle the requests, refer the requester to DMA Program Integrity (919) 647-8000.

D. Information Provided on the Recipient Profile

1. A Recipient Profile is produced for each Medicaid ID number (MID) requested. The profile provides details regarding the payment status of the claims that have been filed with Medicaid for payment.

   a. The profile provides detailed information for every claim billed to Medicaid during the overpayment period requested on the DMA-7063. The profile provides a description of the service, the date of service, the provider number, the amount billed, the payment status, and the amount paid by Medicaid.

   b. The **Provider Summary** page lists the total claims paid to date for each provider during the overpayment period requested on the DMA-7063.

   c. The **Date of Service Summary** page shows the total claims paid to date for each month of the overpayment period requested on the DMA-7063.

   d. For most Medicaid cases, the overpayment amount is established based on the monthly totals reflected on the Date of Service Summary page.

   e. In cases where the totals on the Provider Summary page and Date of Service page are different**,** use the lesser amount of the two.

2. Recipient profiles are produced for Current and Purged history.

   a. The Current History Profile retains claim payment history for 18 months from the date of payment.

   b. The Purged History Profile retains claim payment history for 5 years from date of payment.

(XVI.D)

c. Certain medical procedures and services have limitation criteria that require that the claim data be retained for a longer period of time (i.e. once in a lifetime procedure, dentures, eyeglasses). Claims with limitation criteria are retained for the period of time required on the Current Profile.

3. Profiles include monthly administrative fees paid to managed care providers for recipients enrolled in Carolina Access. These charges are treated the same as any other paid claims and are included in determining the amount of the overpayment. Include these fees when establishing the overpayment regardless of whether the recipient received any additional services.

4. Profiles do not include the amount paid for Medicare Part A and Part B premiums. Those amounts may be found in the History of Medicare Deductibles, Co-Payments and Premiums.

5. Requesting the Initial Recipient Profile and the Follow-Up Profile

a. Providers must file a claim for payment for a Medicaid covered service within 365 days of the date of service. Refer to MA-2395 for exceptions to the filing time limit.

b. If any portion of the overpayment period is within the past 12 months when the initial profile is requested, all claims may not have been paid since providers have 12 months to file a claim.

c. Request an additional profile twelve months after the last month of the overpayment period to obtain all paid claims information when needed. Each new profile provides the total claims paid for the overpayment period as of the date the profile was printed. Refer to X.A.1.a. for procedure to follow if the amount of the overpayment changes.

d. The FRD 470 MEDICAID PROFILE FOLLOW-UP CASE MANAGEMENT REPORT identifies claims for which a follow-up profile must be requested. This XPTR report is generated on the last working day of the month and it is available on the first working day on the next month.

E. How to determine the overpayment amount

1. Complete a DMA-7063 to request a recipient profile for each individual in the case in which there is a period of ineligibility. Request claim information for each ineligible recipient based on the actual months of ineligibility for Medicaid.

2. Determine the amount of claims paid during the period of ineligibility for each ineligible individual. The total for the overpayment period is the sum of the current and/or purged totals shown the on the profile's Date of Service Summary pages.

(XVI.E.2.)

a. For all Medicaid recipients except MQB-B or MQB-E, verify the amount of paid claims on the Date of Service Summary for each ineligible recipient in the EPICS claim.

b. For recipients that are ineligible for MAABD but eligible for MQB-Q, the Medicare X-Over claims and the Part A and B premiums are eligible claims. The overpayment is based on the amount of the non-X-Over claims.

c. For reserve cases, refer to VIII.C. above.

d. For deductible cases, refer to VIII.B. above.

e. For MQB-B and MQB-E recipients, determine the overpayment based on the Part B premiums paid by Medicaid during the period of ineligibility using the History of Medicare Deductibles, Co-Payments and Premiums.

f. Refer to VIII. D. and F., above, to determine the overpayment in a LTC case.

F. How to Read Medicaid Recipient Profiles

1. Recipient Profile Page Header and Claim Header

The following Page Header information is reflected on every page of the current and purged profile and the Claim Header information is reflected on each page of the claim detail pages of the current and purged profiles.

HMBR4002	NORTH CAROLINA TITLE XIX MEDICAID RECIPIENT					(555555555-N)		20081215	
			CURRENT PROFILE PG		8	3,145			
REQ BY:CLERK=X013	FOR:PROV= ALL CLAIM TYPE:A				DATES= 08012008 10312009				
NAME=SMITH JOHN	BASE ID=555555555-N		SEX=M		DOB=12121945		DOD=00000000		
----------CLAIM----------									
CT	ICN	ST SI	PROV #	TP	SP	BILLED PAT-LIAB		SPEND-DN	NET-PD
FDOS	TO DOS	ST	DESCRIPTION						PAID
XOVER	FDOS	TDOS	TOT-BILL	TOT-DED			COINS	TOT-PAY	
XOVER	FDOS	TDOS	ST	DTL-BIL	ALLOWED	PAID	COINS	DED	

(XVI.F.)

2. **Claim Page Header Description (Lines 1-5)**

HMBR4002	The report number is used internally to identify reports to the system and to the users.
NORTHCAROLINA TITLE XIX	Denotes the contract for which this information is presented; Title XIX Medicaid Program.
MEDICAID RECIPIENT	The Medicaid ID number for which claims are requested. If a cross-reference number was requested, the base ID will be presented in the BASE ID field below.
DATE	The date the information was produced. (In YYYMMDD format)
CURRENT or PURGED PROFILE	Indicates the type of profile requested.
PROFILE PG	The page numbers of the profile. The first number is the sequence number within this recipient's profile. The second number is the sequence number within the entire job.
REQ BY CLERK	The clerk ID for whom the profile is produced. (X plus the county's 3-digit county number.)
REQ FOR	This information determines the type of records presented. Defaults to All.
	Prov = If ALL, all providers are selected. Claim Type = If A, all claim types are selected. Dates = The range of dates of services requested. If ALL DATES REQUESTED, all claims will be selected regardless of date of service.
NAME	The name of the recipient on the date the profile was produced based upon the name on the eligibility file.
BASE ID	The Base ID number of the MID requested. This will differ from the above Medicaid Recipient ID if the number requested was a cross-reference ID.
SEX	The sex of the recipient.
DOB	The date of birth of the recipient.
DOD	The date of death of the recipient, if applicable

3. **Claim Header Description (Lines 6-9)**

CT	Claim type. See Appendix A.
ICN	Internal Control Number assigned by EDS.
ST	The status of the claim. See Appendix B.
SI	Supplemental Pay Indicator. This field is used for adjustments only.
PROV NBR	Provider Number for the Billing Provider
TP	The provider type of the billing provider. (FYI only).
SP	The provider specialty of the billing provider. (FYI only).
BILLED	The total amount billed on the claim by the provider.
PAT-LIAB	The patient liability for this claim.
SPEND-DN	The amount of spend-down (deductible balance) for this claim.
NET-PD	The amount paid on this claim by Medicaid.

(XVI.F.)

4. **Provider Summary Information**

The Provider Summary page summarizes all paid claims for each provider number that appears on the recipient's profile for the period of time requested. The Provider Summary is sorted in provider number order. The provider number, provider name, number of services, amount billed and amount paid are presented.

HMBR4002 NORTH CAROLINA TITLE XIX MEDICAID RECIPIENT(900000000-L)				20091115
	PURGE PROFILE PG	45	67	
REQ BY: CLERK=ALW	REQ FOR PROV= ALL CLAIM TYPE:A:	DATES=	06112005	03042006
NAME=DANDURY RICKY	BASE ID=900000000-L	SEX=M	DOB-12201925	DOD=00000000
----------CLAIM----------				
	PROVIDER SUMMARY INFORMATION			

PROVIDER NUMBER	PROVIDER NAME	NUMBER SERVICES	AMOUNT BILLED	AMOUNT PAID
0495000	PHARM SAVE III	0	6,316.81	4,314.08
00635000	WINYAH DISPENSARY OF	0	778.33	306.20
3400000	PRESBYTERIAN HSPITA	9	9,863.05	55.03
3403000	MEDICAL SERVICES	2	34.02	.00
3406000	AMERICAN MEDICAL RES	5	207.64	111.80
3406000	MECKLENBURY EMERGENC	1	19.66	.00
3416000	AVANTE AT CHARLOTTE	0	8,154.50	4,511.00
3425000	AVANTE AT CHARLOTTE	9	51,239.55	40,489.55
345000	WELLINGTON NURS & RE	0	4,950.00	1,485.00
TOTAL		26	81,563.56	**51,272.66**

PROVIDER NUMBER	Each provider which appears on the report. Report is sorted in provider number order.
PROVIDER NAME	The provider's name as it appears on the Provider Master File.
NUMBER SERVICES	Number of services is calculated by accumulating the quantity fields on most claims types. For crossover claims, one unit is accumulated. On inpatient and nursing home claims, one unit is counted for each accommodation and ancillary code, which appears, on the claim. On drug claims, one unit is counted for each NDC drug dispensed.
AMOUNT BILLED	The total amount billed, accumulated from the header, by this provider
AMOUNT PAID	The total amount paid, accumulated from the header, to this provider

5. **Date of Service Summary**

The Date of Service Summary provides a monthly summary of paid claim information for the Medicaid recipient. The Date of Service Summary provides the monthly amounts billed and paid for the time period requested based on dates of service. This report is produced at the same time as the Claim Information and the Provider Summary Information.

(XVI.F.5.)

HMBR4002 NORTH CAROLINA TITLE XIX MEDICAID RECIPIENT(900000000-L)					20091115
		PURGE PROFILE PG		45	67
REQ BY: CLERK=ALW	REQ FOR PROV= ALL CLAIM TYPE:A:		DATES=	06112005	03042006
NAME=DANDURY RICKY	BASE ID=900000000-L	SEX=M	DOB-12201925		DOD=00000000

DATE OF SERVICE SUMMARY

SERVICE DATE	AMOUNT BILLED	**AMOUNT PAID**
06/05	.00	.00
07/05	1,817.63	829.35
08/05	2,093.07	961.85
10/05	29.96	29.96
11/05	2,760.00	.00
12/05	3,305.60	2,661.60
01/06	3,833.68	3,811.34
02/06	3,719.36	3,650.73
03/06	3,795.15	3,757.22
TOTAL	21,354.45	**15,702.05**

SERVICE DATE	The month in which the services were performed.
AMOUNT BILLED	The total amount billed by the provider for the services performed during the month.
AMOUNT PAID	The total amount paid by Medicaid for services performed during the month.
TOTAL	Total amount billed and total amount paid.

6. **Claim Type Codes**

CLAIM TYPE	DESCRIPTION
D	Drug
J	Medical (Physicians. Etc.)
K	Dental
L	Health Check
M	Hospital Outpatient
P	Medical vendor (Optical, Ambulance)
Q	Home Health, Hospice, Personal Care Services
S	Hospital Inpatient
T	Nursing Home (SNF, ICF), Adult Care Home Transportation
W	Outpatient X-Over (Medicare)
X	Inpatient X-Over (Medicare)
O	Physician X-Over (Medicare)

(XVI.F.)

7. **Claim Status Codes**

CLAIM STATUS	DESCRIPTION OF CODE	COUNTABLE OR NON-COUNTABLE
A	Paid posted	Count
B	Paid unposted	Count
C	Denied posted	Do not count
D	Denied unposted	Do not count
F	Full cash refund (Not reflected on DOS Summary.)	Do not count
G	Adjustment pending against original claim	Do not count
P	Partial refund or recoupment	Do not count
R	Accounts receivable active	Count
U	Claim returned to provider (for signature, etc)	Do not count
V	Original claim voided due to full recoupment or recoup/repay done on original claim	Do not count
AR	Void original claim and repay provider	Count
AF	Void original claim and full recoupment	Do not count
1	Claim paid but not yet posted	Count
4	Pending claim for an edit	Do not count
5	Pending claim for an audit	Do not count

G. How to Determine the Service Code for EPICS

1. Use the Provider Summary Information from the recipient profile to determine the provider number with the highest paid amount. Use the service code for this provider claim type when keying EPICS claims.

2. Locate the provider number for the paid claims on the profile to determine the code for the Claim Type. The claim type code is located in the left margin of that provider's billing information. Determine the Service Code that matches the Claim Type based on the Service Code Chart below. Enter this service code in EPICS when the claim goes into Collection Status (CO).

3. **Medicaid Service Codes**

SERVICE CODE	CLAIM TYPE	DESCRIPTION
01	S,X	Inpatient Hospital
02	M,W	Outpatient Hospital
03	K	Dental
04	D	Drugs
05	J,L,O,P	Physician
06	Q	Home Health, Hospice, Personal Care Services
09	N/A	Medicare Premium (Not found on Recipient Profiles)
11	T	Nursing Home (SNF, ICF) & Personal Care Services in Adult Care Home
67	N/A	NC Health Choice (Not found on Recipient Profiles)
71	N/A	Medical Transportation (Not found on Recipient Profiles)

(XVI.)

H. Examples of Claim Types and Claim Status Codes

1. Claim Detail Information (Claim Type: K, J, Q, M, L, P, T and S) Following are examples of the screen for Claim Types K, J, and S. Since claim types Q, M, and L have the same format, we are not including an example of these. We have also included a T claim type, as it is for **Long Term Care** and looks a little different.

a. Examples: Claim Types K, J, and S and T

Line 1 (Same down to NET-PD)

NET-PD	The amount Medicaid paid on this claim

HMBR4002	NORTH CAROLINA TITLE XIX MEDICAID RECIPIENT			(901000000-T)		20061115	
			CURRENT PROFILE PG	1	152		
REQ BY:CLERK=D015	FOR:PROV= ALL CLAIM TYPE:A			DATES= 05012005 06302006			
NAME=HOUGHY AMYEE	BASE ID=901000000-T		SEX=F	DOB=12301978		DOD=00000000	
----------CLAIM----------							
CT	ICN	ST SI	PROV #	TP	SP	BILLED PAT-LIAB	SPEND-DN	**NET-PD**
FDOS	TO DOS	ST	DESCRIPTION					PAID
XOVER	FDOS	TDOS	TOT-BILL	TOT-DED		COINS		TOT-PAY
XOVER	FDOS	TDOS	ST	DTL-BIL	ALLOWED	PAID	COINS	DED
K	102005155602170	A	8993665 027 072	85.00	.00	.00		**38.20**
	052805 052805	A	AMALGAM-TWO SURFACES, PERMANENT				38.20	
J	252006088011539	A	890287X 022 020	304.00	.00	.00		**101.78**
	032506 032506	A	OV NEW PT, COMPLEX-PHYS TIME APPROX 45 MIN				87.53	
	032506 032506	A	SPINE COMPLETE				14.25	
S	252006182317660	A	3400014 060 080	2739.50	.00	.00		**1950.26**
	062306 062506	A	ROOM AND BOARD-PRIVATE OB				1950.26	
	062306 062506	C	ROOM AND BOARD-PRIVATE OB				.00	
	062306 062506	C	MED/SURG SUPPLIES & DEVICES-GEN CLASS				.00	
	062306 062506	C	RECOVERY ROOM-GEN CLASS				.00	
	062306 062506	C	LABOR ROOM/DELIVERY-LABOR				.00	

Note: Nursing home claims are paid based on the per diem times the number of days, minus any patient liability or any third party payment.

T	252006195309226	A	3415131 080 086	708.00	623.40	.00	**84.60**
	062506 063006	A	ALL-INCLUSIVE R&B PLUS ANCILLARY				.00
T	252006197324929	A	3415131 080 086	826.00	.00	.00	**727.30**
	070906 071506	A	ALL-INCLUSIVE R&B PLUS ANCILLARY				727.30

(XVI.H.1.a.)

Line 2

FROM-DOS-TO DOS	The from and thru dates of service.
ST	Status of claim. See Appendix B
DESCRIPTION	The diagnosis description. If the diagnosis code billed is invalid, no description will print.
PAID	The amount determined to be payable by Medicaid for this line item.

b. **Example - Claim Type P**
This example is for vision care. Refer to E.2. and E.3., above, for Page Header and Claim Header information.

HMBR4002	NORTH CAROLINA TITLE XIX MEDICAID RECIPIENT					(900000000-P)			20061115
				CURRENT PROFILE PG		1		76	
REQ BY:CLERK=D003		FOR:PROV= ALL CLAIM TYPE:A				DATES= 07012006 08312006			
NAME=CLAYE KANDY		BASE ID=900000000-P		SEX=F		DOB=07031975		DOD=00000000	
----------CLAIM----------									
CT	ICN	ST SI	PROV #	TP	SP	BILLED PAT-LIAB		SPEND-DN	**NET-PD**
FDOS	TO DOS	ST	DESCRIPTION						PAID
XOVER	FDOS	TDOS	TOT-BILL		TOT-DED			COINS	TOT-PAY
XOVER	FDOS	TDOS	ST	DTL-BIL	ALLOWED		PAID	COINS	DED
P	252006216215300	A	8802023 075 091		20.69	.00	.00		**20.69**
	072006 072006	A	FRAME ZYLONITE COMBINATION					10.95	
	072006 072006	A	SINCLE VISION, GL/PL,SPH+OR-PLANO TO 3.0					9.74	

c. **Example - Claim Type: D (Drug)**
Drug claims are a little different in that they only show the actual date of service. There will never be a "From and To Date of Service".

Line 1 Every line is the same down to Net Paid.

NET-PD	The amount Medicaid paid on this claim.

HMBR4002	NORTH CAROLINA TITLE XIX MEDICAID RECIPIENT					(900000000-L)			20061115
				CURRENT PROFILE PG		21		55	
REQ BY:CLERK=CE01		FOR:PROV= ALL CLAIM TYPE:A				DATES= 02202005 07312005			
NAME=BLACK SANDY		BASE ID=900000000-L		SEX=M		DOB=04121961		DOD=00000000	
----------CLAIM----------									
CT	ICN	ST SI	PROV #	TP	SP	BILLED PAT-LIAB		SPEND-DN	**NET-PD**
FDOS	TO DOS	ST	DESCRIPTION						PAID
XOVER	FDOS	TDOS	TOT-BILL		TOT-DED			COINS	TOT-PAY
XOVER	FDOS	TDOS	ST	DTL-BIL	ALLOWED		PAID	COINS	DED
D	052006145028819	A	0505123 026 085		27.45				**24.27**
	050306	A	HUMULIN N 100U/ML VIAL						
D	052006145028570	A	0505123 026 085		147.80				**132.58**
	052506	A	REZULIN 400MG TABLET						

(XVI.H.1.)

d. **Examples - Crossover Claims (Claim type O, W, and/or X)**
Crossover information is presented on claims, which have crossed over from Medicare for payment of the Medicare coinsurance and/or deductible by Medicaid.

Line 1 - Refer to E.2. and E.3., above, for claims header information through Line 2 to Net Paid.

Line 3

XOVER	Indicates Medicare Crossover
FDOS	From date of service
TDOS	To date of service
TOT-BILL	Total Billed to Medicare
TOT-DED	Total Medicare Deductible
COINS	Coinsurance (20% not paid by Medicare)
TOT- PAY	Medicare Payment
Lines 01 - XX	Breakdown **of the Medicare Claim into Line Items**

```
HMBR4002      NORTH CAROLINA TITLE XIX  MEDICAID RECIPIENT      (900000000-L)          20061115
                  *PURGE* PROFILE PG                                    16      38
REQ BY:CLERK=ALW          FOR:PROV= ALL CLAIM TYPE:A          DATES= 06112003  03042005
NAME=DANDURY  RICKY     BASE ID=900000000-L       SEX=M       DOB=12201932     DOD=00000000
------------CLAIM----------------
CT        ICN            ST  SI        PROV #          TP     SP      BILLED PAT-LIAB      SPEND-DN      NET-PD
    FDOS    TO DOS        ST            DESCRIPTION                    PAID
    XOVER    FDOS         TDOS               TOT-BILL        TOT-DED          COINS      TOT-PAY
    XOVER    FDOS         TDOS       ST      DTL-BIL         ALLOWED          PAID       COINS        DED

O     102004149673330          A*    8901612  022  018                    8.37          .00         .00                  8.37
                                      ROUTINE MEDICAL EXAM
   XOVER    102803 102803                    56.00              .00                                    8.37         33.49
   01       102803 102803  A                 56.00             41.86                          33.49    8.37          .00

W     102004079879900          A     3435134  080  086        155.60              .00                        .00        155.60
                                      ROUTINE MEDICAL EXAM
   XOVER    010304 011704                  2880.00             100.00           55.60       928.00
   01       010304 011704                     .00                .00            .00           .00                    .00
```

* The Status code on this line is the Medicaid Status code. The status code on Line 4 is the Medicare status code. The Medicare Status code is irrelevant to the Medicaid Fraud Investigator. The only status the Investigator needs to be concerned with is the Medicaid status, and the amount Medicaid paid on the claim.

XVII. CITATIONS AND REFERENCES

Social Security Act, Title XIX, Section 1909
42 CFR 455 "Program Integrity"
Social Security Act 1137, 4359.40 ff
IRS Code of 1954, Section 6103(l)
44 CFR 17926 (March 23, 1979) amended at 51 CFR 7178 (February 8, 1986, effective May 29, 1986)
Social Security Act, Title 1902(a)(7)
42 CFR 431.301-305
Privacy Act of 1947 (PL 93-579), Section 552b(7)
10 NCAC 26G
10 NCAC 26G.08
10 NCAC 24B .0306
20 NCAC 32S .0306
NCGS 7B-601 and 7B-110B
NCGS 108A-64
NCGS 108A-80, 143B-153
NCGS 14-100
Title 11 of The United States Code
NCGS 105A-8
NCGS 105A-12