
BENEFICIARY FRAUD AND ABUSE POLICY AND PROCEDURES

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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 **local agency**, disposition and reporting of these cases must be consistent.

II. LEGAL RESPONSIBILITY AND REFERENCES

Both the state and the **local agency** 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-Medicaid" sets forth the requirements for the control of fraud and abuse in the Medicaid program by the state Medicaid agency, **the Division of Health Benefits (DHB)**.**
- 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 recipients.**
- C. North Carolina Administrative Code **10A NCAC 22F .0706** contains procedures established by **DHB** regarding recipient 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 **DHB** and administered by each **local agency**. 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 Statute 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 recipient 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.

1. **Felony:** 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).
2. **Misdemeanor:** 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. North Carolina General Statute 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.

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 other 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 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 **local agency** 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 **beneficiary**.

1. **Criminal Statute - North Carolina General Statue 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 **North Carolina General Statue 108A-64** are cases involving \$400.00 or less.

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 – North Carolina General Statute 1-52** is 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.

If the debtor 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 debtor must circle the word "Seal." The investigator should contact the **local agency** attorney or county attorney for further information regarding this point.

D. Statutes Governing Confidentiality

1. **General Statutes 108A-80, 143B-153, 108A-25** require each **local agency** to be 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 **agency**. Therefore, it is necessary for each investigator to have discussed these statutes with their agency legal counsel or county attorney.
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 applicants and beneficiaries 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.

3. **Section 1137(5)(A), 435.940ff of the Act**, which requires agencies to exchange information in order to verify income and eligibility of applicants and beneficiaries, 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 applicants and beneficiaries 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 beneficiaries
- 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 applicants and beneficiaries. Source: As re-designated, 44 FR 17926 (March 23, 1979)

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

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

The agency must provide copies of these provisions to applicants and beneficiaries 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 applicants and beneficiaries 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 435.940ff). 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 a **beneficiary** 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 **beneficiary** and legal counsel have the legal right to view and have a copy of the information in the eligibility or services record at any time except for:

- a. Information that the **local agency** is required to keep confidential by state or federal statute or regulation.

- 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 **local agency** 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 **beneficiary** 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 **agency** with information.

It is also important to distinguish between intent to defraud and omission, neglect, or error by the **agency** in helping a **beneficiary** 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 **beneficiary**, parents and/or financially responsible adults of a minor child, legal spouse of a **beneficiary**, or a representative acting in behalf of a **beneficiary**. 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 determine that **client** is guilty, an Intentional Program Violation (IPV) claim would be established in the **NC FAST Program Integrity (PI) portal**.
- 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 **local agency** with required information. For these situations, an Inadvertent Household Error (IHE) claim would be established in the **NC FAST PI portal**.

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 regards 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 **agency**, and that it will induce the **agency** to authorize assistance to which the client is not entitled or to assistance greater than that to which the client is entitled, and

- d. The **local agency** does in fact rely upon the statement given by the applicant/beneficiary, and awards assistance to which the beneficiary is not entitled or assistance greater than the beneficiary is entitled, and
- e. The local **agency** has informed the applicant/beneficiary, of the law relating to fraud and appropriate information has been entered in the agency record, and
- f. The applicant/beneficiary has signed a statement that all information given by the applicant/beneficiary and/or their representative pertaining to their eligibility is correct and true to the best of their knowledge.

V. PREVENTION

A. Interviewing

- 1. A key to fraud prevention is skillful interviewing during **the face to face or telephone application process. It is also important to use fraud prevention methods found in this section during the evaluation of mail-in, faxed and online applications, at reviews and when changes in situation are reported.**
- 2. **Prior to conducting a review, examine the case history and documentation.** Take note of previous work history, income, prior reserve such as bank accounts, insurance policies, etc., and other eligibility factors.
- 3. The **face to face interview or telephone** contact involves two-way communication. Be specific and thorough in the questions asked. Phrase questions in a way the applicant will understand. Give the applicant a chance to respond in their own words. Listen carefully to the applicant's responses. Ask specific follow up questions, evaluate their reactions and document the responses.
- 4. Follow these steps at interviews:
 - a. Explain to the applicant his obligation to report all changes in situation within ten (10) calendar days after they occur.
 - b. Inform the applicant of the consequences of failure to report changes. Stress the penalties for fraud and misrepresentation.
 - c. Explain to the applicant how to report changes and the required time frame for reporting changes.
 - d. Inform the applicant about computer matches in which the **agency** participates.
 - e. Explain the meaning of fraud. Give the applicant a copy of the fraud form, [DSS-8627](#).

- f. If the applicant's living standards appear to exceed their income, question the applicant regarding unreported income.
- g. **If conducting a face to face or telephone review**, ask the beneficiary about any changes that have occurred since application or the last review.

B. Documentation and Verification

Thorough documentation and verification provide 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 **Online Verification System/Online Verification (OVS/OLV)** inquiry to ensure each applicant/beneficiary does not already receive assistance in your **local agency** or another county local agency. Document the results of the inquiry.
2. Complete inquiries, using all SSNs provided. Check all 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 **agency**. 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 **agency** 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.

(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 local agency devise a plan to ensure that every caseworker and social worker involved with a beneficiary/family communicate changes in the situation to each other, 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 agency'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 agency 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 DHB will be referred to the local agency in writing for investigation. The local agency's PI investigator should enter a pending referral in NC FAST within seven days of the referral. If an IPV or an IHE is established, create a claim in NC FAST to agree with the findings. Follow the instructions in the NC FAST job aids, PI- Create Referrals/Investigation Cases and PI – Establish a Claim/ Product Liability Case.

Regardless of the results of the investigation, the agency must provide the referring DHB Program Integrity (PI) Beneficiary Fraud Consultant with a copy of the Investigative Summary ([DHB-7058](#)), of the investigation within 60 days from the date of the referral letter.

B. Quality Assurance Reviews

During their regular review, the **DHB Office of Compliance and Program Integrity/Quality Assurance** staff sometimes detects possible fraud or misrepresentation. Cases found with suspected of fraud or misrepresentation will be referred to the **local agency's PI Unit** by the assigned **DHB PI Beneficiary Fraud Consultant** for further investigation.

The PI Unit must enter a pending referral in the **NC FAST PI portal** **within seven days** of date of the referral. A copy of the **DHB-7058, Investigative Summary**, of the investigation must be sent to the **referring DHB PI Beneficiary Fraud Consultant** **within 60 days** from the date of the referral letter.

C. Private Sector and Other Agencies

If you receive information from other agencies, institutions, providers, other beneficiaries 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. Local Agency Staff

During the application and review processes, the **agency's** staff may discover cases of possible fraud, abuse, or misrepresentation that need to be evaluated and/or investigated for a possible overpayment. A PI referral should be keyed in **NC FAST using the job aid, PI- Create Referrals/Investigation Cases**. There are two types of in-house referrals:

1. **Front-end Referral:** This referral is made during the application or recertification process prior to disposition/recertifying It is made to prevent the release of erroneous issuances due to potential fraud. Usually the investigator has **five workdays** to complete this investigation and instruct the worker on their findings.
2. **Regular Referral:** This referral is made at any time other than during the application/recertification process. When a case is in active status; however, consideration should be given to cases still currently potentially ineligible to prevent further overpayments. **The investigator has 180 days from the date of referral to complete.**

E. Other sources include but are not limited to:

1. Computer matches in **OVS/OLV** such as ACTS, DMV, SOLQ, SDX, BENDEX, NEW HIRE, ESC/**SCUBI**, **The Work Number, Asset Verification System (AVS)**, etc. Also, check the following reports: FRR (Financial Resource Report), BEER (Beneficiary Earnings Exchange Report) and the Veteran's Affairs match.
2. Tax records (unreported personal property, automobiles, farm equipment)
3. Register of Deeds, and Clerk of Court records (marriage, transfers of property)

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 Public Safety** (DOC/NC DPS) 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

The **date of discovery** is the day PI receives the referral. **All investigations and establishment of claims should be completed within 180 days of the date of discovery. Claims for court cases must be established within 30 days of the court decision.**

A. Preliminary Investigation

When a referral for possible Medicaid fraud or misrepresentation is received from any source, or when there is an indication a **beneficiary** may have received benefits to which he was not entitled, the **local agency** 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 **NC FAST**. **Follow the instructions using the job aid, PI- Creating Referrals/Investigations Case.**

1. Review **all agency** benefit cases and systems (OVS/OLV, etc.) for that **beneficiary**, including Medicaid, Work First, and Food and Nutrition Services. These cases 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 **beneficiary** understood and accepted responsibility for reporting changes in circumstances to the **agency** in a timely manner.
 - a. Determine from documentation and verification documents if an adequate explanation was given to the **beneficiary** regarding their rights and responsibilities.

- b. Determine whether the **beneficiary** was offered assistance with obtaining requested verifications at each contact with the local **agency** during the application or recertification process. This is necessary to ensure that the beneficiary understood and accepted responsibility for reporting changes to the **agency** in a timely manner.
 - c. **If the **agency** did not meet their obligation, any resulting overpayment is deemed an agency error and cannot be collected from the beneficiary.**
3. Determine from the case if the information is already known to the agency.
- a. Information reported in a timely manner to **any agency** staff is considered information known to the agency.
- An overpayment resulting from information known to the agency but not communicated to the appropriate caseworkers is deemed an agency error (AE) and cannot be recouped from the beneficiary. An AE claim should NOT be created claim in NC FAST.**
- b. 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 **beneficiary's** continuing eligibility, no further investigation is required.
- Example: A private citizen calls to report that a **beneficiary's** husband is employed. A review of the case 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 **agency** reason to believe fraud or misrepresentation has occurred, create an **Investigative Case in NC FAST** and conduct a full investigation. Refer to the job aid, **PI- Creating Referrals/ Investigation Cases**, for instructions.

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 **beneficiary**, employers, financial institutions, other agencies, and collaterals, etc.

2. Document **all actions on the Notes tab of the NC FAST Investigative Case (IC)** using complete names and dates.
3. If you are unable to substantiate the allegations, **document your findings on the Notes tab of the IC** and close the investigation as unsubstantiated. Refer to the job aid, **PI- Creating Referrals/ Investigation Cases**, for instructions.
4. If verifications substantiate that fraud/misrepresentation exists, schedule an interview with the **beneficiary**.

C. Building the Investigative Case

To build an investigative case (IC), clearly document proof of each step taken in the application/authorization process on the **Notes tab of the IC**.

Certain information should **be attached to the IC** when available, including, but not limited to the following:

1. All application and recertification **paper copies or NC Fast attachments**.
2. All narratives pertaining to the overpayment from the paper eligibility file **and/or those listed on the NC FAST Insurance Affordability case, Income Support case, and PDC(s)**.
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 should be kept on the **NC FAST IC** of every contact had with the **beneficiary** and on any action taken on the case. Record the date of contact on the entry if not entered the same day. Use full sentences and quote what was actually stated whenever possible. Do not enter any opinions.
6. Be sure you have reviewed all benefit **cases (paper and electronic)** in your agency to determine what information the **beneficiary** provided and what was verified. Communicate with Service Workers.

Remember, if the **beneficiary** reported something to anyone within the **local agency**, it is considered as "known to the agency." If the **agency** failed to follow up in a timely manner, any resulting overpayment is considered an agency error. Medicaid policy prohibits collecting these types of overpayments from the **beneficiary**.

D. Investigative Interview

1. Conduct an interview with the **beneficiary** and/or representative if a case appears to be **beneficiary** responsible fraud or misrepresentation.
2. The investigative interview with a **beneficiary** 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 **beneficiary** in an area where you will have privacy. Inform the **beneficiary** they are free to leave at any time.
 - b. Inform the **beneficiary** you are investigating for possible overpayments. Ask the **beneficiary** if there is anything, they wish to tell you that they have not previously revealed to the **local agency**.
 - c. Discuss the subject of fraud. Explain the **beneficiary's** rights and responsibilities to determine if the **beneficiary** understands the concept of fraud. Ask the **beneficiary** to explain their rights and responsibilities in their own words.
 - d. Review the case with the **beneficiary**. Cover the eligibility points in question. Confirm that the **beneficiary** made an application and did in fact make the statements documented on the signed form(s).
 - e. Ask again if the **beneficiary** wishes to change any of the statements made or if they have any new information to report.
 - f. Use open-ended questions and mirror questions. Allow the **beneficiary** 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 **beneficiary** continues to affirm that all statements previously made are true, confront the **beneficiary** with the known facts.
 - a. If the **beneficiary** 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 **beneficiary** admits wrongdoing and wishes to acknowledge the truth, take a statement and have the **beneficiary** sign and date it. It is recommended that a witness also sign the statement. Also, review the case and have the **beneficiary** 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 **all verified** information had been reported timely.
3. Allow time for changes:
 - a. Allow 10 calendar days for the **beneficiary** to have notified the **local agency** 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 workdays for Timely Notice ([DSS-8110](#)) to the **beneficiary** of the change in eligibility.

Example: In an ongoing MAA-Q case, **beneficiary** starts working on **07/02/2020**. He gets paid monthly and he receives his first paycheck on **07/31/2020**. The **beneficiary** has until **08/10/2020** to report the income. The **beneficiary** reports by the **10th**. The worker acts on the reported information and sends a notice to the **beneficiary** on **08/11/2020**. The first month a change could be affected is **09/2020**.

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 (including Family Planning Program. See F & C Manual section, [MA 3265](#)) had the information been reported correctly and timely.

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

Example: A **beneficiary** who is ineligible as MADN may be eligible for the Family Planning Program (FPP).

Example: A **beneficiary** 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 appropriate resources and income levels for the period of ineligibility. Refer to the [MA-2252](#), Non-MAGI Medicaid Income/Reserve for the current and previous three years' 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 **beneficiary**.
 - c. If multiple changes occur, re-budget each change in the order in which it occurred. Refer to [MA-2250](#) for an explanation of what constitutes a change in income.
6. Once the period of ineligibility is determined, request a Medicaid/NCHC **Beneficiary** Profile from the **Division of Health Benefits** via the [DHB-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 **Beneficiary** 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 **beneficiaries** ineligible due to excess income or transfer of assets.
 - b. For all **beneficiaries** who are ineligible due to excess resources or other categorical requirements (e.g., SSI), 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. Overpayment Methodology for New or Additional Deductible due to Excess Income

When unreported income is discovered, it may result in the **beneficiary** having to meet a new or additional deductible. Refer to section [MA-2360](#), Medicaid Deductible, to determine which medical expenses can be applied towards the deductible.

1. Determine the period(s) in which the **beneficiary** was ineligible for CN coverage due to income that exceeded the income limit.
 - 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 local agency.
2. Change Discovered During the Current Certification Period
 - a. Verify and project changed, or unreported income based on policy requirements.
 - b. If the **beneficiary** has an unmet deductible, send a timely notice to increase the deductible. There is no overpayment since the **beneficiary** was not authorized for Medicaid.
 - c. If the **beneficiary** 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 **beneficiary** 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 **beneficiary** 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 **Beneficiary** Profile via the [DHB-7063](#) for the period authorized.

Refer to XVI. below for instructions on how to read Medicaid/NCHC **Beneficiary** Profiles and determine the amount of claims paid on behalf of the **beneficiary** 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.
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:

- 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 **beneficiary** had no deductible, send a [DSS-8110](#) giving the **beneficiary** 10 workdays notice of the additional or new deductible amount.
 - (1) Allow the **beneficiary** the opportunity to provide any additional medical expenses to meet the deductible.
 - (2) Apply all allowable expenses to the additional deductible.
 - a) If the **beneficiary** meets the additional deductible, there is no overpayment.
 - b) If there is an unmet deductible, request a Medicaid/NCHC **Beneficiary** Profile for the period of ineligibility.
 - (3) 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:

05/02/2019 A single man, 65, applied for Adult Medicaid. He reported his only source of income was Social Security Disability in the amount of \$702. He reported having \$7,000 unpaid medical bill from 01/2019. His application was approved for ongoing MAA-N with a certification period from **05/01/2019** to **04/30/2020**. He did not qualify for retro coverage as the bill was more than 3 months prior to application.

05/13/2019 The **beneficiary** began working.

06/14/2019 The **beneficiary** received his first monthly check for **\$1,375** which he did not report. Had **beneficiary** reported his earnings timely within 10 calendar days (**6/24/2019**), and another 10 workdays for a timely notice (**7/10/2019**), the change would have affected his Medicaid beginning **08/2019**.

- 01/01/2020 Beneficiary's Social Security increased from \$702 to \$723.
- 03/03/2020 The beneficiary came to local agency for a redetermination of eligibility. He reported his Social Security increase. During the review, the caseworker discovered through OVS that the beneficiary had wages beginning the second quarter of 2019. The beneficiary admitted he had been working but had forgotten to report it. The caseworker sent the employer a letter to verify earnings.
- 03/10/2020 The employer verified the beneficiary's monthly earnings of \$1,375 beginning in June 2019. Since the income exceeded the CN income limit, Medicaid was evaluated with a deductible. The beneficiary was sent a 10-day notice to advise him of the new deductible. The deadline to respond was 03/24/2020.
- 03/20/2020 The beneficiary provided the unpaid \$ 7,000 unpaid bill from 01/2019. Beneficiary said he did not expect to have bills to meet the deductible for ongoing eligibility.
- 04/01/2020 The beneficiary was sent a timely notice to terminate benefits effective 04/30/2020.

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: 05/01/2019-10/01/2019 and 11/01/2019 – 04/30/2020.

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., recalculate the beneficiary's income from 06/2019 to 10/2019. In the second c.p., budget 11/2019 and 12/2019 separately from 01/2020 - 04/2020 because the beneficiary's income changed in 01/2020 due to the COLA increase.

Rule: Determine the deductible for each certification period.

Calculate the deductible as follows:

<i>May 2019 thru October 2019</i>	<i>November 2019 thru April 2020</i>
<i>Deductible months: June 2019 – October 2019</i>	<i>Deductible months: November 2019- December 2019</i>
\$ 702.00 Original RSDI	\$ 702.00 Original RSDI
<u>- 20.00</u> Deduction	<u>- 20.00</u> Deduction
= \$ 682.00	= \$ 682.00
\$ 1,375.00 Wages	\$ 1,375.00 Wages
<u>- 65.00</u> Earned Income Deduction	<u>- 65.00</u> Earned Income Deduction
= \$1,310.00 / 2	= \$1,310.00 / 2
= \$ 655.00 Net Earned	= \$ 655.00 Net Earned
+ \$ <u>682.00</u> RSDI	+ \$ <u>682.00</u> RSDI
= \$1,337.00	= \$ 1,337.00
<u>- 242.00</u> Maintenance	<u>- 242.00</u> Maintenance
= \$ 1,095.00 Excess Income	= \$ 1,095.00 Excess Income
<u>X 5</u> Months 06/2019-10/2019	<u>X 2</u> Months 11/2019-12/2019
= \$ 5,475.00 Deductible	= \$ 2,190.00 Deductible
	<i>January 2020 thru April 2020</i>
The beneficiary provided the \$7,000 bill from 01/2019.	\$ 723.00 RSDI-COLA Increase
	<u>- 20.00</u> Deduction
	= \$ 703.00
\$ 7,000	\$ 1,375.00 Wages
<u>-\$ 5,475</u>	<u>- 65.00</u> Earned Income Deduction
\$ 1,525 Remainder unpaid medical	= \$ 1,310.00 / 2
	= \$ 655.00 Net Earned
	+ <u>703.00</u> RSDI
	\$ 1,358.00
	<u>- 242.00</u> Maintenance
	= \$ 1,116.00 Excess Income
	<u>X 4</u> Months 01/2020 - 04/2020
	\$ 4,464.00
	+ <u>\$ 2,190.00</u> Months 11/2019 - 12/2019
	\$ 6,654.00 Deductible 11/02019 - 04/2020
	<u>- \$ 1,525.00</u> Remainder unpaid medical
	\$ 5,129.00 Unmet deductible

The unmet deductible for 11/2019 to 04/2020 is \$5,129.

Rule: Send a [DSS-8110](#) to notify the **beneficiary** of the new or revised deductible, allowing the **beneficiary** time to provide unpaid bills to meet the deductible.

Since the **beneficiary** provided the \$7,000 bill from 01/2019, he was able to meet the deductible of \$5,475 for the first cert period ($\$7,000 - \$5,475 = \$1,525$). The remainder \$1,525 was applied to the second cert period decreasing the deductible amount to \$5,129.

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

A Medicaid/NCHC **Beneficiary** Profile was requested for 11/2019-04/2020. The **Beneficiary** Profile indicated that Medicaid paid \$8,675 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 \$5,129 because it is less than the Medicaid expenditure amount of \$8,675.

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 **beneficiary**, 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 **beneficiary** was authorized effective June 2. It is later discovered that a \$115 charge that had been applied to the deductible was incorrectly applied. (The **beneficiary** forged their 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.

This is applicable only if the error was on the part of the beneficiary. If the local agency makes an error in applying expenses to the deductible, it is an agency error and cannot be recouped from the beneficiary. Therefore, no claim should be entered in NC FAST. Document the Investigative Case of the error and close the referral as unsubstantiated.

C. Overpayment Methodology for Excess Resources

1. Determine the period(s) in which the **beneficiary** 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 local agency.
 - c. If the **beneficiary** states that resources are for burial purposes, apply the burial exclusion policy. This policy can be applied retroactively, allowing the **beneficiary** to use cash funds to purchase burial assets and exclude up to the \$1,500 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 **beneficiary** 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 **beneficiary** 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 **Beneficiary** Profile via the [DHB-7063](#) to **DHB Office of Compliance and Program Integrity/ Quality Assurance**.

- b. If there is more than one period of ineligibility, request a Medicaid/NCHC **Beneficiary** 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 **Beneficiary** 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 number of months the **beneficiary** was ineligible. Refer to the **SSA Bendex data on the OVS/OLV from the eligibility case** for the Medicare premium(s) for the overpayment month(s).
 - 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 1: **Beneficiary** was found eligible and authorized June-November with no reserve. It is discovered at a subsequent review that the **beneficiary** had a certificate of deposit with a balance of \$8,700, resulting in excess reserve of \$6,700. **Beneficiary** 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 2: **Beneficiary** 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 the excess reserve is less than the amount of claims paid.

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.

Example 3: A MAA-N **beneficiary** was found eligible and authorized April-September and October-March. At the next review it is discovered that the **beneficiary** failed to report a savings account that caused excess reserve in the amount of \$450 from initial authorization. **Beneficiary** 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 **beneficiary** profile shows a total of \$526 paid in claims. The overpayment for this period is the excess reserve of \$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 $\$450 + \$127 = \$577$.

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 **beneficiary** authorized April-September is terminated at the end of the c.p. due to failure to complete the review. The **beneficiary** re-applies and is authorized December-May. At the review at the end of the latter c.p., it is discovered that the **beneficiary** had an unreported bank account that caused excess resources during both c.p.'s. The maximum excess resources for April-September were \$1,660 and for December-May were \$450. The total amount of claims paid for both periods was \$1,095. The overpayment amount is \$450 (the lesser of \$1,095 and \$1,660).

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.

1. Transfer of asset sanctions applies to institutionalized **beneficiaries** 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 beneficiary stops receiving institutional services. Refer to [MA-2240](#) for procedures and regulations applicable to transfer of assets at the time of the transfer.

Cases with a transfer of assets on or after November 1, 2007, should only be referred to Program Integrity if the sanction cannot be keyed until after the 4th month due to notification requirements. PI is responsible for recouping the period beginning with the 4th month until the month the sanction becomes effective.

2. Three separate calculations are required to determine the amount of the overpayment when the LTC **beneficiary**, 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 **beneficiary** 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 **beneficiary** should have been sanctioned for transfer of assets. Refer to [MA-2240](#). If no sanction is applicable, the overpayment is computed based on the excess resources prior to the date of the allowable transfer.

- a. If the **beneficiary** 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 **beneficiary** 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 **beneficiary** 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](#) 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) Round this number to the lowest whole number
 - (5) The result is the number of months of sanction

- b. **Transfer occurring on or after November 1, 2007** - Refer to [MA-2240](#) 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 **Beneficiary** Profile via the [DHB-7063](#). Refer to XVI. for instructions on how to request a Medicaid/NCHC **Beneficiary** Profile.
 - a. **The DHB PI Beneficiary Fraud Consultant** will review the **beneficiary** profile to determine which claims are considered non-covered during the transfer of assets sanction.
 - b. The **Consultant** 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 the consultant at **DHB, Office of Compliance and Program Integrity** at (919) 527-7700.
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 result, do the following:
 - a. Determine the amount Medicaid paid for medical services other than cost of care during the sanction period by requesting a Medicaid/NCHC **Beneficiary** 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.

If the sanction period has not been exhausted, apply the remaining months of sanction to the ongoing case and re-budget based on PLA budgeting.

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

07/11/2007— A single individual transfers a Certificate of Deposit worth \$24,000.

08/01/2012 - The individual enters a nursing facility.

08/13/2012 - 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.

12/05/2012 - The **local agency** 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 08/13/12.

If transferred assets are returned to the **beneficiary**, 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 **beneficiary's** name.

Step 2- Determine the sanction period.

The starting point in this case is 08/13/2012, 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 transfer	\$ 24,000
2.)	Divide by private NF rate	<u>÷ \$ 5,000</u>
3.)	Equals number of sanction months	4.80

The 4.80 is rounded down to 4. **The four-month sanction begins from the month of transfer July 2007 to October 2007.** The individual is eligible for Medicaid for LTC 11/01/2007 – 01/31/2007.

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

The agency verified through **DHB** that the total paid for “cost of care” from 8/1/2007 – 10/31/2007 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 **beneficiary** is ineligible for full Medicaid because their \$875 SSA benefits exceeds income limit. Therefore, we calculate a deductible.

Ineligible months in c.p: 8/01/2007-10/31/2007

\$ 875	SSA Income
- 20	General Exclusion
= \$ 855	Countable Income
- 242	PLA Maintenance
= \$ 613	Excess Monthly Income
x 4	Months
= \$ 2,452	Deductible for 08/2007 – 10/2007

Beneficiary’s total deductible for the four months he is ineligible for cost of care is **\$2,452**. 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 08/2007 – 10/2007 was **\$2,068**.

Beneficiary was advised of the deductible and given the opportunity to provide old or new bills. The **beneficiary** did not provide bills. Since the **\$2,068** Medicaid paid is less than the deductible amount of **\$2,452**, the **\$2,068** 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
<u>\$ 2,468.00</u>	Cost of Services other than cost of care
\$ 22,468.00	Total Overpayment

The overpayment amount of **\$22,468** is entered into **NC FAST** with Service Code 11.

b. Transfer on or after November 1, 2007.

- 02/11/2017** A single individual transfers a CD worth \$20,000 to his three children after his wife dies.
- 08/01/2019** The individual, aged 75, enters a nursing facility.
- 08/13/2019** A MAA application is received for a 75-year-old individual for help with cost of care. He reported income of **\$1,085.00** from SSA and a homesite worth \$96,000. He stated he intended to return home. No resources were reported. The case was authorized effective **8/01/2019-7/31/2020**
- 12/04/2019** The **beneficiary's** daughter came into the local agency to discuss her father's case. She informs the caseworker she's now her father's POA and provided a copy of the agreement. During the conversation, she revealed that after her mother died in 8/2016 her father transferred a CD worth \$20,000 to her and her 3 brothers. She stated he had given the money to them to help with the down payment to purchase homes of their own.

The caseworker advised this had not been reported previously and could impact her father's ability to receive LTC Medicaid. She also explained that her father would be responsible for his cost of care during the period a sanction was imposed. She advised once the county evaluated the transfer, she would be notified. The POA stated would discuss with her siblings to discuss. She informed the caseworker that one of her brothers was in the military and stationed out of the country.

- 5/07/2020** The caseworker was unable to enter the sanction effective date until the 6th month due to a State hearing and notification requirements. The case was referred to Program Integrity to recoup the sanctions for April and May 2020. Included with the referral was a copy of the [DMA-5181](#) (Calculating Penalty Period).

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 **02/11/2017**, prior to the application date of **08/13/2019**.

Step 2- Determine the sanction period

Based on the [DMA-5181](#)(Calculating Penalty Period), the starting point in this case is **08/01/2019**, which is the earliest date the individual was institutionalized and applied for Medicaid. The Lookback date is 08/01/2014, 5 years prior to the starting point.

- 1.) Total uncompensated transfers **\$ 20,000**
- 2.) Divide by private NF rate **\$ 6,810**
- 3.) Equals number of months **2.94**
- 4.) Determine whole month sanction period by counting forward from the date otherwise eligible **04/01/2020 – 05/31/2020**
- 5.) Enter fractional month (from 3 above) and multiply by 31 **.94 X 31 = 29.14**
- 6.) Add **20** days to the sanction in 4. Above. Drop partial day. **04/01/2020 – 06/29/2020**

The total sanction period is from **04/01/2020 through 06/29/2020**.

The **beneficiary** is eligible for Medicaid for LTC from **06/30/2020 – 06/30/2020**.

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

The agency verified through **DHB** that the total paid for “cost of care” from **04/01/2020 – 06/29/2020** was **\$12,800**. The cost of care amount of **\$12,800** is less than the **\$20,000** the **beneficiary** transferred. The **\$12,800** 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 **beneficiary** is ineligible for full Medicaid because her \$1,085 SSA benefits exceeds income limit. Therefore, a deductible is calculated.

PLA Certification period: **04/01/2020-06/30/2020**

\$1,085	SSA Income
<u>\$- 20</u>	General Exclusion
\$1,065	Monthly Income
<u>- 242</u>	PLA Maintenance
= \$ 823	Excess Income
<u>x 3</u>	Months
= \$2,469	Deductible for 04/01/2020 – 6/30/2020

Beneficiary's total deductible for the two months he is ineligible for cost of care is **\$2,469**. 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 **04/01/2020 – 06/29/2020** was **\$2,748**.

Beneficiary was advised of the deductible and given the opportunity to provide medical bills. The **beneficiary** did not provide any bills to reduce his deductible. The **\$2,469** Medicaid deductible is less than the claim amount Medicaid paid of **\$2,748**. The **\$2,469** will be used to compute the overpayment.

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

\$	0.00	Excess Reserve
\$	14,420.00	Cost of Care expenses
\$	<u>2,469.00</u>	Cost of Services for other than cost of care
\$	<u>16,889.00</u>	Total Overpayment

The overpayment amount of \$16,889 is entered in NC FAST with Service Code 11.

E. Special Assistance (SA) Medicaid Cases

Beneficiaries who are eligible for the Special Assistance (SA) Cash payment are automatically eligible for Medicaid. When a SA beneficiary is found to be ineligible for the SA cash payment received, the Medicaid eligibility for the ineligible period must be evaluated.

The SA cash program is **NOT** a Medicaid benefit. The program is administrated by the Division of Aging and Adult Services. For guidance on SA cash overpayments, refer to the SA manual. **DO NOT** enter the SA cash overpayments into NC FAST.

Use the following when it is determined that a SA beneficiary is ineligible for the cash payment received:

1. Evaluate the beneficiary for Medicaid under any other coverage group during the period of the SA ineligibility
2. If the beneficiary remains to be eligible for full Medicaid, there is no Medicaid overpayment.
3. If the beneficiary 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. Only enter the **SA Medicaid overpayment** into NC FAST.

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 **beneficiary** profile for patient liability.

Example: A **beneficiary** 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 **beneficiary'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 **beneficiary's** representative and the **local agency** given timely notice, the PML would have been increased effective April 1. The total overpayment is \$100, \$50 for each of the 2 months.

6. If the unreported income causes the **beneficiary's** total countable monthly income to exceed the nursing facility's Medicaid reimbursement rate, private rate, or all other predictable medical expenses ([MA-2270](#)), then the **beneficiary** was ineligible for assistance with the cost of care. Budget the **beneficiary** PLA with a deductible. Refer to [MA-2270](#).
 - a. Request a Medicaid/NCHC **Beneficiary** 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 **beneficiary'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 **beneficiary** would have been authorized for Medicaid except for cost of care. The overpayment is the amount paid for cost of care.
- e. 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 Skilled Nursing Facility (SNF) charges for a limited period of time. See [MA-2270](#), 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 **beneficiary** has Medicare, and you discover an understated liability, ask the **beneficiary** or Nursing Facility about any hospitalizations or Medicare covered days during the overpayment period.
 - b. If Medicare payment is involved request a **beneficiary** 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 **Beneficiaries for MQB-B**

1. Unreported Income

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

- a. Using actual verified income, re-compute the **beneficiary's** eligibility for full coverage. **Refer to B. above "Calculation of Overpayment due to Excess Income"**.
- b. Compare the verified income to the income limits for MQB-B to determine if the **beneficiary** 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 **beneficiary** on the [DSS-8110](#) of their MAABD-M deductible status.
- e. Also advise the **beneficiary** on the same [DSS-8110](#) of their status for other MQB classifications.

2. Unreported Resources

When a MAABD-N **beneficiary** is determined to have been ineligible for full coverage due to unreported resources, evaluate the **beneficiary'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 **beneficiary** continued to be eligible for limited coverage.
- b. Notify the **beneficiary** on the [DSS-8110](#) of any change in current eligibility, including their eligibility for MQB-Q.

3. Request a **Beneficiary** Profile for the Overpayment Period.

- a. If the **beneficiary** is eligible for MQB-Q, you will count only the total paid for non-Medicare covered services in the overpayment amount. See XVI. Medicaid/NCHC Profiles for further instructions.
- b. Medicare covered services are what we call crossover claims (claim types **A and B**). 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 **Beneficiary** Profile, for further instructions.
- c. If the **beneficiary** is eligible MQB-B, MQB-Q, MQB-E or MWD only, all payments made for medical services are considered an overpayment.
- d. If the **beneficiary** would have had a deductible, compare the amount Medicaid paid to the amount of the deductible. The overpayment is the lesser of the two.
- e. If the **beneficiary** 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: **Beneficiary** 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 **beneficiary** 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 **beneficiary** remains eligible for MQB-Q for the entire c.p. The Medicaid/NCHC **Beneficiary** 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 **beneficiary** 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 **beneficiaries** are not eligible for MAABD-N as the reserve limit is lower for that coverage group. These **beneficiaries** may be eligible for MAABD-M with a deductible if reserve is reduced during the period of ineligibility.
2. If a **beneficiary** is found to be ineligible for MQB-Q due to unreported income, evaluate the **beneficiary's** eligibility for MAABD-M with a deductible. Follow the instructions in B. above. If the **beneficiary** 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.
3. For ineligible MQB-Q **beneficiaries**, determine the amount Medicaid paid by requesting a Medicaid/NCHC **Beneficiary** Profile.
4. If a **beneficiary** is found ineligible for MQB-B or MQB-E and did **not** receive MAABD- C/N, MAABD-MN or MQB-Q, do not request a Medicaid/NCHC **Beneficiary** 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 **SSA Bendex data on the OVS/OLV of the eligibility case for the Medicare premium(s) for the overpayment month(s)**.

I. Potential SSI Medicaid Overpayments

When the **local agency** becomes aware of a SSI **beneficiary** 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 exists:

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 **beneficiary** 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 **beneficiary** recently inherited \$50,000.
4. If the **beneficiary** failed to report income or resources to SSI in a timely manner, there is a potential Medicaid overpayment. A report should be referred to the local SSA Office for a possible overpayment. If SSA determines the beneficiary ineligible for SSI ineligibility, there may be a Medicaid overpayment.
Example: The interview of the **beneficiary** or the verification of resources establishes that that **beneficiary** has \$50,000 in CD at Wachovia and they were acquired several months ago.
5. If the local **agency** becomes aware that a SSI **beneficiary** has resources and the resources make the **beneficiary** ineligible, the **agency** should report this information to the Social Security Administration. Once SSA terminates SSI, the local **agency** should follow the guidelines MA 2900, VIII.I., 1-4 above.
6. These are other examples of when a case should be referred to the fraud unit for a possible overpayment:
Example 1: A SSI **beneficiary** loans someone else his card and the other person receives benefits to which he was not entitled.
Example 2: The SSI **beneficiary'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 **beneficiary** 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 **local agency** records of the dates for which the **beneficiary** claimed a need for reimbursement for transportation and reimbursement was given, either to the **beneficiary**, or the provider of transportation services.
2. Request a Medicaid/NCHC **Beneficiary** 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 **beneficiary** and/or provider of transportation services for any dates medical services were not rendered to the **beneficiary**.
5. Enter a Medicaid claim in **NC FAST** using the **Product Delivery Case** number and program code the **beneficiary** was receiving at the time of the overpayment occurred. **The Medicaid service Code will be 71.**
6. Depending on the circumstances, the debtor may be the **beneficiary**, 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 **local agency** 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 **agency** in consultation with its local legal advisor. Consistency in application of these standards is imperative.

B. Responsibility of Overpayment

1. The PI investigator/caseworker must determine whether an existing overpayment is the result of suspected fraud, client 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 cannot be collected from the **beneficiary**.
3. If a client error occurred, take immediate action to correct ongoing eligibility and refer the case to the agency's PI unit for investigation.
4. If fraud or misrepresentation is suspected, refer the case to the agency's PI unit for investigation, making sure to give all information obtained to date.

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

C. Determining Who the Debtor Is

1. Debtors may include financially responsible adults, including parents of children, adult **beneficiaries**, and legal spouses of **beneficiaries**, 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-beneficiaries**, such as the applicant's representative, if they fail to report income and/or assets of the **beneficiary**.
 - b. Other **non-beneficiaries** may also be debtors if they use a **beneficiary's** Medicaid card to obtain benefits.
 - c. If the **beneficiary** "loaned" the Medicaid card to the **non-beneficiary**, they are co-debtors in the overpayment claim.

Example: The **beneficiary** may be a victim of theft. If someone steals a **beneficiary's** Medicaid card, and uses it to obtain Medicaid benefits, then the thief is considered the debtor. In this case the **beneficiary** would not be a debtor. However, if the **beneficiary** loaned the card to the **non-beneficiary**, then he is a co-debtor in the overpayment claim with the **non-beneficiary**.
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 **beneficiary** was at the time of the overpayment and who the financially responsible adult(s) was during the overpayment period.
 - b. If a **beneficiary** is determined to be incompetent, he/she may not be considered a debtor. However, an overpayment may still exist. In this case, the representative, often the Power of Attorney (POA), 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 **beneficiary** and the community spouse are possible debtors. Often an LTC **beneficiary** 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 **beneficiary**. 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 **beneficiary(s)**. Each case is unique in the factors that will decide whom the debtors are.

Example: A daughter with Power of Attorney (POA) applies for LTC for her mother. She fails to report all her mother's assets. During the application process the POA transfers all assets into her own name. In this case, the POA may be found to be the debtor due to her benefiting from the transfers or failure to report information. Also, there may be a sanction for the **beneficiary**.

- 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/**beneficiaries** may have a representative who applies for benefits on their behalf. If the representative knowingly misrepresents a **beneficiary'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 **county's assigned DHB PI Beneficiary Fraud Consultant** at (919) 527-7700.

D. Guidelines for **creating claims in **NC FAST** when the case head is not the debtor or is not the only debtor.**

- 1. Create a claim in **NC FAST** in the case head's name, since the claim must be tied to the correct **Product Delivery Case** or Case ID number (legacy EIS cases only) and authorization period(s) for **Medicaid** program.
- 2. If the **non-beneficiary** debtor does not already have a CNDS ID, create one in **NC FAST** using the instructions in the job aid, **Registering Persons**. **Once the CNDS ID has been created, add the debtor to the PLC.**
- 3. Enter as many debtors as appropriate.

E. Combining Legacy EIS Cases on a PLC in NC FAST

- 1. A legacy EIS case may have more than one Medicaid overpayment. Combine multiple overpayment periods for a case into one claim in **NC FAST** as long as the overpayment periods are within the same **Medicaid** program category, (i.e., MAA, MAD) **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 [job aid, PI- Establish a Claim / Product Liability Case](#).

F. Investigative Summary

1. Complete the [DHB-7058](#), Investigative Summary, upon completion of an investigation, detailing all factors causing the overpayment, the overpayment period, and amount of the overpayment. **Attach a copy to the Investigative Case (unsubstantiated cases) or the Claim (substantiated cases) in NC Fast.**
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 Local Agency's 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 agency's procedures.
5. All available options must be utilized to attempt collection on any debt owed to **DHB**.

G. Referral to **Local Agency's Board of Social Services**

1. The Local Agency's 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 **beneficiary** willfully and knowingly, with intent to deceive:
 - (1) Make a false statement or representation,
 - (2) Fail to disclose a material fact,
 - (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) **Beneficiary'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 **Local Agency** 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 **agency** should establish a good working relationship with the District Attorney, County attorney or Agency 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 specifics of the case or about program policies, procedures and regulations. Do not schedule court proceedings until all documentation is in hand.

- b. The **agency** should expect advice from the **agency's** attorney or county attorney on whether a case has enough evidence 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 **agency** should meet with the attorney to discuss such a relationship. Only by discussing expectations will a worthwhile effort towards prosecution evolve.

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 on 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 **beneficiary's** home, hours the **beneficiary** 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.

- b. Only testimony from the record should be given to avoid violating confidentiality. 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 fully developed your case, everything you need will be contained in the investigative summary.
- c. Answer all questions as concisely as possible. If you must 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.
 - (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 **NC FAST** the following occurs:

1. The [DHB-8010/8010S](#), 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. **The notice is produced based on the debtor's language preference located on the Person Page>Evidence Tab.**
 - a. The initial overpayment amount may change if additional claims are paid for medical expenses that were incurred during the period of ineligibility. The [DHB-7059](#), Notice of Change in Overpayment for Medical Assistance, notifying each debtor of the change in the overpayment must be **manually** sent.
 - b. **Attach a copy of the manual [DHB-7059](#) to the PLC.**
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 [DHB-8010](#) is mailed to the mailing address listed in **NC FAST** for each debtor.
 - a. If no address is listed for the debtor on the Debtor Detail screen, **NC FAST** will send the [DHB-8010](#) to the **local agency** address responsible for the referral.
 - b. When the [DHB-8010](#) is returned to the **agency** 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 [DHB-8010](#).
 - (2) Forward the notice to the new address. File a copy of the revised notice in the case and document the change.
 - d. If no alternate address is located, file the [DHB-8010](#) and documentation of all sources searched for an address in the case.

4. The report, **EPI433**, 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 SSN and name
 - b. The Program Code
 - c. **Claim overpayment amount**
 - d. **Investigative Case Reference number and PLC**
 - e. Date notice was mailed and the final hearing date (60th day).
5. The notice instructs the debtor to contact the **local agency's** 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 **beneficiary** has the right to an appeal when benefits are modified or terminated. In the case of fraud/misinterpretation, the **beneficiary** may request an appeal of the corrected eligibility determination made during the investigation.

1. If a timely notice is sent and the **beneficiary** 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](#).
2. If the initial hearing decision upholds the **agency's** action, any benefits received by the **beneficiary** 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 **NC FAST**.
3. The automated [DHB-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](#) for good cause definition):
 - a. Send a request to the agency's **DHB PI Beneficiary Fraud Consultant** to set the NC Debt Setoff indicator to "Hearing" in **NC FAST**. 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 agency's **DHB PI Beneficiary Fraud Consultant** to remove/change the indicator upon receiving the final hearing decision.

XI. ADMINISTRATIVE COLLECTION PROCEDURES

If the **Local Agency** Board or its designee chooses not to refer the case for prosecution, the following options are available:

A. Voluntary Repayment Agreement

1. The **debtor** 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 [DHB-7060](#), Voluntary Repayment Agreement (VRA).
 - a. **Negotiate full repayment between 36 - 60 months. Extensions over 60 months must be approved by DHB OPCI.**
 - b. **If a debtor is unable to repay the overpayment within 60 months, a hardship request must be faxed on county letterhead to the agency's assigned DHB PI Beneficiary Fraud Consultant at (919) 800-3186 with the following:**
 - (1) **Product Delivery Case**
 - (2) **The proposed payment and number of months it will take to repay the overpayment**
 - (3) **Reason for the hardship request**
 - (4) **Signatures of the PI staff completing request and PI Supervisor**

Do not execute the VRA with the debtor until a response has been received from the DHB PI Beneficiary Fraud Consultant.
2. Always have the VRA notarized and keep a copy in the file. Send copies to Medicaid, and WF for their files.
3. When a debtor fails to make 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 debtor.
 - a. If the debtor 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 a debtor with an outstanding debt, the **local agency** must file a claim against the deceased's estate for restitution.
 - c. If the word "Seal" appears next to the debtor'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 debtor. If further information is needed, contact your county attorney.

B. Voluntary Wage Withholding

Complete the [DHB-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:

- a. Send the employer a copy via certified mail.
- b. Give the debtor a copy.
- c. Attach a copy to the **NC Fast Product Liability Case (PLC)**.
- d. Send copies to Medicaid, and WF and FNS for their files.

Always have the debtor sign a VRA as well as the Voluntary Wage Withholding agreement. Then, if the debtor 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 **beneficiary** is found liable, the court may enter a judgment against the **beneficiary** for the amount owed to **local agency**. Civil Court procedures may also be used when a **beneficiary** 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 **beneficiary** 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 **beneficiary** 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 **local agency** 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 agency attorney or county attorney may have to consult with the Attorney General's office.

D. Delinquent Accounts

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

1. **Probation Office:** For debtors 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 debtor is complying with their court obligation, assure that their taxes are not intercepted.
2. **Clerk of Court:** For debtors 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.

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 **beneficiary** owes **DHB** 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 **local agency** should collect the overpayment amount first, as the **agency** 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 **beneficiary** through verification with the Clerk of Court regarding the existence of assets of which the **agency** was unaware. At the point the investigator verifies resources that created ineligibility for Medicaid a claim should be established in **NC FAST**.
4. Request a Medicaid Profile via the [DHB-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 **local agency**. Contact your local county Clerk of Court to obtain the letter.

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.

2. Wage Garnishment Criteria:

- a. The garnishment process cannot be initiated until all administrative collection methods are exhausted. The local **agency** must attempt to establish a cash repayment agreement. If the debtor fails to meet the terms of the agreement, garnishment proceedings cannot be initiated until the account is 60 days delinquent. If the debtor makes a payment after the garnishment process begins, the garnishment procedure will continue.
- b. Garnishment is not an option if a debtor is required to pay restitution for fraudulently receiving Medicaid benefits pursuant to a criminal court order. However, if the debtor 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 debtor 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.
- f. An order for garnishment may not be entered if the court finds that the order jeopardizes the debtor'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 debtor'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 **local agency** to have the judgment removed at the Clerk of Court within 30 days of full repayment of the judgement and the costs of court.

Local agencies 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 debtor fails to appear for the hearing or fails to make a plea regarding the matter. Once a judgment is entered, the **local agency** 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 **beneficiary**.
- 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 the **agency** has obtained a judgment. A copy must be attached to the petition.
- g. The name and address of the garnishee.

- h. The debtor's verified monthly disposable income. Attempt to verify this through the employer or debtor. If this is not available, use the **Division of Employment Security (DES)** information as last resort.
 - i. Verification that the proposed garnishment does not exceed 20% of the debtor's monthly disposable income.
 - j. The Petition for an Order of Garnishment must be served on the debtor, and on the garnishee usually the current employer of the debtor.
4. Instructions for Completing Petition for Order of Garnishment
- 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 **local agency**.
 - b. A district court judge in the county where the debtor 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 debtors of public assistance. The petition must allege that the defendant is a past or current **beneficiary**. 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 **agency** 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 **agency** has obtained a judgment for a sum certain against the debtor. 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.

- i. The petition must give the debtor's monthly disposable income.
- j. No more than twenty percent (20%) of the debtor's monthly disposable income can be withheld. If the fraudulent benefit cannot be recovered in one payment, the petition must state the amount the **local agency** wishes to be withheld from the debtor'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 debtor 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 debtor 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 debtor, 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.

- h. The amount to be garnished is based on the debtor'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 local **agency** 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 local **agency** may place a lien against a debtor's property, both personal and real, because of claims paid or to be paid on behalf of that debtor following a court judgment which determined the benefits were incorrectly paid for that debtor.

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 individual is seeking relief from all or part of his debt. This section is for informational purposes regarding the bankruptcy process. According to a Supreme Court decision in 1934 this is the purpose of the bankruptcy law:

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

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 **local agency's** investigator must research each situation as it occurs. This is important in order to ensure the debtor pays as much of their debt to the local **agency** (creditor), as the law will allow. Once you learn a debtor has filed for bankruptcy, it may be necessary to call on the agency attorney or county attorney for advice on how to approach the Medicaid overpayment.

B. Notification

The first order of business should be that the local **agency** is notified by the court that this debtor has filed for bankruptcy, and the local **agency** 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 debtor failed to list the local **agency** as a creditor. In order to receive any distribution from the bankruptcy estate, the local **agency** 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 local **agency** to attend this meeting. The local **agency** 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.

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 **local agency** 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 local **agency**. However, the Bankruptcy Judge has the final say.
4. Take a close look at your case and take necessary steps to ensure the local **agency** is not violating bankruptcy law. Once the **agency** has been notified, or becomes aware the debtor 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 the agency's **DHB PI Beneficiary Fraud Consultant** for assistance.
5. To prevent tax intercepts on a claim, send a request to the agency's **DHB PI Beneficiary Fraud Consultant to add the bankruptcy indicator in NC FAST**. This includes wage garnishment or wage withholding. Make sure to contact the employer to stop these actions.
6. If the local **agency** 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 debtor 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.

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 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, usually three to five years, through a trustee. The plan must be based on the debtor's anticipated income. Most 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.

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.

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 **NC FAST** is delinquent the debtor's North Carolina tax refund will be intercepted and applied toward the overpayment claim in **NC FAST**.

XIV. NC FAST REPORTING REQUIREMENTS

DHB Office of Compliance and Program Integrity/Quality Assurance is responsible for the administration of the Medicaid **beneficiary** investigations conducted by **local agencies**. To comply with state and federal reporting requirements, each local **agency** is responsible for entering all client responsible overpayment claims into **NC FAST**. Refer to the job aid, **PI – Establish a Claim/ Product Liability Case** for instructions.

A. Local Agency Incentive Payments

To offset the **local agency's** administrative costs for program integrity activities and staff and provide cost savings through increased investigations and collection of Medicaid overpayments, the **Division of Health Benefits (DHB)** implemented a **local agency** incentives program for collections of client responsible overpayments effective February 1, 1997.

1. The local **agency** receives monthly incentive payments from the **DHB** based on collections for client responsible overpayments.
2. The calculation for the local **agency's** incentive payments is based on one-half of the non-federal share of collections for client responsible medical assistance overpayments.
3. The state and federal reimbursement rates vary slightly from year to year. The local **agency's** incentive is based on the actual state reimbursement rates that were in effect during the overpayment period captured in **NC FAST**.
4. Incentive payments are based on collections keyed into **NC FAST**. Collections are passed from **NC FAST** to the Medicaid Accounting System and incentive payments are credited back to the local **agency** through the monthly Medicaid Adjustment Register.

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

1. The local agency must enter a referral in NC Fast for each fraud complaint that is initiated or investigated. Also, the agency is required to establish an overpayment claim within **180 days** from the date of discovery. The NC FAST PI Portal has been designated as the system to track the agency's Program Integrity activities and generate reports.
2. Data in NC FAST on PI referrals, overpayment claims, and funds collected on overpayments are available on reports generated in NCXPTR and NC FAST, as they are entered. Refer to the job aid, PI- Reports, for a list of reports accessible to the agency.

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 **NC FAST**. 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 and Nutrition Services (FNS)** programs as the result of Intentional Program Violation (IPV) or Inadvertent Household Error.

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-NC FAST
Medicaid - Third Party Recovery (TPR)	Non-NC FAST
Food and Nutrition Services	NC FAST
Work First/AFDC	NC FAST
Medicaid/NC Health Choice	NC FAST

The **Division of Health Benefits** applied for a second agency code for Medicaid since debtors are submitted to DOR separately for **NC FAST** and TPR. Since 80% of Medicaid's tax intercepts are for TPR Medicaid, **NC FAST** Medicaid was assigned the newest DOR agency code.

B. NC Debt Setoff Process in **NC FAST**

1. The **NC FAST** 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 **NC FAST**. The PI Investigator needs to maintain the data in **NC FAST** 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, **FNS** and Work First/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 **NC FAST** 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 **NC FAST** 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 **NC FAST**/CNDS.

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 active collection status.

- 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 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 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 FNS) 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 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 SSN that exists in **NC FAST**.
 If a debtor does not have a valid SSN in **NC FAST/CNDS**, the debtor cannot be submitted for tax intercept. In addition, if an invalid SSN is in **NC FAST/CNDS**, it is possible that a tax refund of another individual will be incorrectly intercepted.

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 **NC FAST** for each program type with the individual debtor's information for each successful intercept and the dollar amount that was intercepted for each debtor.

1. The [DSS-8653](#), Notice to Debtor, is mailed to the debtor's last known mailing address in **NC FAST**.
 - a. If the notice is returned to the **local agency** by the postal service, forward the notice to the mailing address shown in the **agency's** file, if different.
 - b. If the notice cannot be successfully delivered by the postal service, file the returned notice on the case.
 - c. The intercept will be processed since the notice was sent to the best available address known to the agency.
 - d. DOR notifies the debtor that their tax refund has been intercepted, in whole or in part using **the address listed on the debtor's tax return**.
 - e. The **EPI431**, NC Debt Setoff 30-Day Notice Report lists all debtors that were intercepted, and all information listed on notice.
2. Content of Notice to Debtor

The Notice to Debtor, [DSS-8653](#), 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, **FNS**, and/or Work First/AFDC debt(s) owed to the **local agency**.

- a. 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.
- b. 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.

- c. The notice includes the debtor's **last four digits of their** social security number as it exists in **NC FAST/CNDS**, the debtor's name and the last known mailing address in **NC FAST**.
- d. The notice reports the current balance owed for the outstanding claim(s) that meets the requirements for NC Debt Setoff for FNS, AFDC/**Work First**, 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 AFDC/Work First of \$200 and Medicaid of \$3,000. The tax refund that is intercepted is \$500. The Notice will show the \$200 amount for AFDC/Work First 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 are listed on the Notice to Debtor and the EPI431, NC Debt Setoff 30-Day Notice Report.

Example: The debtor has eligible delinquent claims for **FNS** 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.
- e. The debtor is informed to contact the **local agency's** Program Integrity Section as listed on the notice if they have questions concerning the intended action.

3. Multiple Notices

- a. It is possible for a debtor to receive multiple copies of the Notice to Debtor if he has eligible claims with different **local agencies** that are successfully intercepted.

- b. Each notice will provide the debtor with the **local agency's** name, address and telephone number for the **agency** 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 local **agency** 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 local **agencies** for the same program type.

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

- d. If the debtor has eligible claims that were successfully intercepted in multiple **agencies**, the agencies will be listed on the **EPI431**, NC Debt Setoff 30 Day Notice Report. Refer to 4., below, for detailed information about this report.

4. **EPI431**, NC Debt Setoff 30-Day Notice Report

The **EPI431**, NC Debt Setoff 30-Day Notice Report, lists the debtors whose taxes were successfully intercepted and were mailed a **DSS-8653**, Notice to Debtor. The report is produced for each Investigator within the local **agency**. The report is 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 (OAH) and meet all 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.
 - (2) The debtor must mail or deliver the original and one copy of the petition requesting the hearing to the OAH 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 27609
(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 the **local agency** on the 35th day.
- c. If the debtor waives their right to a hearing, **send a request on the agency's letterhead to the agency's DHB PI Beneficiary Fraud Consultant. The request should include the Debtor's name, PDC number, balance, and tax intercept amount. Once the request is keyed, NC FAST will process the payment immediately.**

The debtor may wish to waive their right to the appeal if he agrees with the intercept and his current outstanding balance is less than the intercepted amount since **NC FAST** 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 **Local Agency** 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 copy of the petition with OAH and a copy must be served on the opposing party, which is the **local agency**.
 - d. See the "Petition for a Contested Case Hearing" and the OAH instructions for completing the form.
 - 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. The local agency's DHB PI Beneficiary Fraud Consultant will add the litigation indicator on the NC FAST Debtor Indicators tab upon receiving notification of a debtor's petition for a hearing from the agency 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.

If the litigation indicator is not keyed into NC FAST by the 35th day, the intercepted amount will be applied as a payment against the eligible claim(s).

- (1) When the litigation indicator is present on the NC FAST Debtor Indicators tab, a payment/refund cannot occur as the debtor is still in the "Request Appeal" stage.
 - (2) The indicator will remain unchanged until the local agency's DHB PI Beneficiary Fraud Consultant receives written notification of the tax appeal decision from the Attorney General's Office.
 - (3) If the appeal is in favor of the debtor, the local agency's DHB PI Beneficiary Fraud Consultant will immediately release the tax refund to begin the refund process as interest is accruing for every day the money is held until the intercepted funds are refunded to the debtor.
- b. The valid statuses on the NC Debt Setoff/ Intercepts screen are as follows:

Pending Applicable to:
- DOR offset pends for 35 days (normal process)
- Litigation Hold (Offset pends until hearing conclusion).

Posted Applies to:
- DOR offset has been applied to claim(s)
- Debtor waives right to a hearing and request offset post immediately. (PI staff must send formal request to State)
- Litigation decision is in favor of County. Offset posts to claim(s)

Refunded Displays for:
- Refund is released to debtor
- Refund can be generated by system or keyed manually by State staff

4. Hearing Decision Reached

Once a hearing decision is reached by OAH, the **agency's DHB PI Beneficiary Fraud Consultant** will update the **litigation** indicator on the Debtor Indicators screen based on the decision.

- a. If the hearing decision is in favor of the **local agency**, **NC FAST** will process the payment immediately after the **litigation** indicator is removed.
- b. If the hearing decision is in favor of the debtor, the refund process will begin once the **litigation indicator** is removed. The DHHS Controller's Office will issue a manual refund to the debtor, plus any interest accrued and possible collections fee.
 - (1) Since no payment is credited through **NC FAST** while there is a **litigation indicator** showing, the **DHB PI Beneficiary Fraud Consultant** must remove the indicator.
 - (2) Any debtor with a **litigation** indicator on the Debtor Indicators screen will not be eligible for DOR selection until the agency's **DHB PI Beneficiary Fraud Consultant** removes the block. The debtor will also appear on the **EPI429**, Claims Exempt from NC Debt Setoff Report, until the indicator has been removed.

F. Phase III - Application of Payments in **NC FAST** and Refunds

1. Schedule for Applying Payments

The process for applying payments 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 unless an appeal is requested or if the debtor has not waived their appeal rights, or when the litigation indicator is removed in **NC FAST**.

2. How Payments Are Applied

- a. **NC FAST** receives 3 files from DOR, one for each program type: Medicaid, FNS and AFDC/Work First (WF). Once the appeal process has been fulfilled, **NC FAST** applies the payment across all eligible claims that were initially selected for submission to DOR for each program type that has an intercept.

- (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 claim(s) for a single program type, then **NC FAST** can potentially receive an intercept for all three program types for any given debtor.

Example: The amount available for intercept is \$1,000. The debtor has eligible claims submitted to DOR for FNS for \$400, AFDC/Work First for \$200 and Medicaid for \$700. The first \$400 intercept will be applied to the FNS program. Since there is \$600 still available from the intercept, it will be applied to the next program, AFDC/Work First. There is still \$400 remaining of the intercept. The remaining intercept balance will be applied to Medicaid, which is next program with an available claim balance.

If the claim balances remain the same at the time the intercept payments are applied in **NC FAST**, the FNS and AFDC/Work First claims will each be paid in full. The Medicaid balance will be reduced to \$300.

- (3) If the amount intercepted from DOR is for eligible claims in 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 FNS or AFDC/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.
 - c. If the claim is paid in full by the intercepted funds, the claim is closed in **NC FAST**.
 - 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 will display as “DOR” on the **Financial screens**. Refer to **NC Fast job aid, PI-View a Payment on a Product Liability Case**.
3. NC Debt Setoff Indicator
- 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 **reset on the Debtor Indicators tab**. This will allow the unpaid claims with and outstanding balance to be evaluated for future DOR selection.
4. Refunds to Debtors
- a. The refund checks are processed weekly.
 - b. The **EPI107**, NC DEBT FIN RFD report lists all refund check that were processed. Information included on the report are the amount that is to be refunded to the debtor for DOR over collections and the date the refund check will be written.

Refund checks are written and mailed to the debtor by the DHHS Controller’s Office.
 - 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, unless the tax refund was intercepted in error.
 - d. There are exceptions that may come about between the time the debtor was intercepted by DOR and the time the application of payment 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 changed to Closed Status, "CL" (i.e. Balance gets paid off).
- (3) The claim changes to some other status (i.e. Transfer Status, "TR". Applicable to FNS and Work First).

G. Reports for NC Debt Setoff

There are several reports available in **NC FAST** that track claims as the debtors are selected for intercept of their North Carolina tax refunds. Relevant reports include the following:

1. **EPI429**, Claim Debtors Exempt from NC Debt Setoff Report
2. **EPI213**, Claims Selected for NC Debt Setoff Report
3. **EPI431**, NC Debt Setoff 30-Day Notice Report

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 and applies the interception in the same order as the DOR intercepts.

NCEL Intercept process:

1. DHHS provides a file to NCEL each week. Each weekly file replaces the previous week's files. It reflects **NC FAST's** 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.
3. **NC FAST** sends a notice, [DSS-8234](#), to the debtor regarding the interception and the claim balance.
 - a. The amount intercepted, applied, and that the claim is paid in full or,
 - b. The amount intercepted, applied, and the remaining balance of the claim or,
 - c. The amount intercepted, applied, and the amount to be refunded.
4. Unlike DOR tax interceptions, the debtor does not have a right to a hearing or appeal regarding the NCEL interception.

XVI. NORTH CAROLINA TITLE XIX MEDICAID /NCHC **BENEFICIARY** PROFILES

A. Purpose of the **Beneficiary** Profiles

The Medicaid/NCHC **Beneficiary** Profile provides detailed claims information of medical expenditures and services Medicaid paid on behalf of the authorized **beneficiary**. This section contains the process to follow in requesting a **beneficiary** profile as well as detailed explanations of the information listed. In compliance with HIPAA regulations, DHB will only release the **beneficiary** profile to individuals authorized to obtain the protected health information.

B. Profile Requests for **Client Responsible Overpayments**

1. Upon determining the period of ineligibility, request a **Beneficiary** Profile for each ineligible **beneficiary** to determine the amount of medical claims Medicaid paid.
 - a. Complete a [DHB-7063](#), **Beneficiary** Request Sheet for each **NC FAST** case. The form is located on the [DHHS Policies and Manuals website for Health Benefits/NC Medicaid](#).
 - b. Instructions for completing the [DHB-7063](#) are located on the back side of form. Mail or fax the completed **form** to:

Division of Health Benefits
OCPI/Quality Assurance Section - 18
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax 919-800-3186

- c. **Profiles are normally available the Monday after the request is submitted. They are loaded within 2 weeks of the request to the local agency's Secure folder in NTRACKS, under Report2Web.**

If the profile has not been received within 3 weeks of the original request, send an email to the agency's assigned **DHB PI Beneficiary Fraud Consultant** to check the status of your original request. Include the referral number, fax submission date, and service date(s) requested in box of the email. The Consultant will advise whether your request was received or if it needs to be resubmitted.

2. Requests for Transfer of Assets Sanction Overpayments
 - a. Complete the [DHB-7063](#) to request the **Beneficiary** 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 **beneficiary's** living arrangement, whether LTC, PLA or CAP.

- b. The **DHB PI Beneficiary Fraud Consultant** orders the profiles in **NCTRACKS** and reviews them to determine which claims were non-covered during the sanction. The **Consultant** 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. Requests for the Family Planning **Program (FPP)** Profiles

- a. When the **beneficiary** is not eligible for **the original Medicaid program category received, they may be found eligible for FPP. The investigator must request an FPP profile to exclude these charges from the overpayment. The FPP profile is requested using the [DHB-7063](#) and marking the following:**

- (1) Check the “YES” box for the question, “Is this request for Family Planning **Program** profiles?”
- (2) Check the **FPP** box next to the Dates of Service the profile is needed.

DO NOT order an **FPP profile if the original coverage was MAFD.**

- b. The **DHB PI Beneficiary Fraud Consultant** will order the profile from **NCTRACKS** and review to determine which claims are **FPP** related services. The **Consultant** will prepare a letter to advise the investigator of the total amount of **FPP** claims. The **FPP** claims amount listed claims must be deducted from the total overpayment amount.

4. Requests for Expedited Profile due to Excess Reserve Overpayments

- 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 **beneficiary** reduces reserve on other expenditures.
- b. Paid claims information is viewable to DHB staff prior to the generation of a profile.
- c. Contact your agency’s assigned **DHB PI Beneficiary Fraud Consultant** to **request the current amount of paid claims reflected in NCTRACKS for the overpayment period. There must be an open Medicaid referral in NC Fast for excess reserve to perform this request. The excess reserve case must meet** 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 **beneficiary** was authorized.
 - (2) The Investigator needs to notify the **beneficiary** of the approximate overpayment amount before the **beneficiary** reduces reserve by spending it elsewhere.
- d. All telephone requests must be followed up **with a [DHB-7063](#) via mail or fax to DHB, Office of Compliance & Program Integrity (OCPI)/Quality Assurance Section.**

Example: The caseworker verifies from the FRR that a LTC **beneficiary** 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 **beneficiary** 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 **DHB** by telephone and quickly establishes \$9,870 in claims paid to date for the period of ineligibility. The **beneficiary** is able to reduce reserve for ongoing coverage by paying the overpayment amount. If the **beneficiary** 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. Requests for MQB-B or MQB-E are not Necessary
 - a. The only payments for MQB-B, MQB-E, MQB-Q **beneficiaries** are the Medicare Part B premiums. The overpayments for these claims are determined by totaling the Medicare premiums paid by **DHB** for those **beneficiaries** during the period of ineligibility.
 - b. Refer to the **SSA BENDEX tab on the OVS/OLV** verifications of the benefit case to determine the Medicare premium rate during the overpayment period(s). **For a history of Medicare premium rates prior to 2016, please refer to the SSA website, <https://www.ssa.gov/policy/docs/statcomps/supplement/2015/2b-2c.html>.**

C. Profile Requests 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 ensure 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 agency's **DHB PI Beneficiary Fraud Consultant at:**

**Division of Health Benefits
OCPI/Quality Assurance- 18
2501 Mail Service, 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 **beneficiaries** for whom Medicaid records are needed, along with their CNDS ID number and social security number. **Without this identifying information, the request cannot be processed.**
- b. The dates of service needed.
- c. Signature of GAL, along with a business phone number where he/she can be reached, if there are questions.
- d. **DHB's Office of Compliance and Program Integrity** will send the profile by certified mail to the GAL at the court in which he/she serves, or hand delivered requiring proof of identity upon delivery.

2. Social Workers

Social workers may ask the PI 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:

- a. The social worker must complete form [DHB-7098](#), **Local Agency Authorization to Disclose Health Information**. The **local agency's** director or his designee must sign the form.

b. Mail or fax the completed [DHB-7098](#) to:

Division of Health Benefits
OCPI/Quality Assurance Section - 18
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax 919-800-3186

3. **Beneficiaries**

When the **beneficiary or their authorized representative** requests their Medicaid profile:

- a. Advise the **beneficiary** or their legal representative to contact **DHB's Office of Compliance and Program Integrity Call Center** at (919) 527-7749, or the **local agency** may provide the form, [DHB-7097](#), **Beneficiary Authorization to Disclose Health Information** for them to complete and sign. Fax the completed form to DHB at (919) 800-3186.
- b. **DHB Office of Compliance and Program Integrity** will process the request and forward the Medicaid/NCHC **Beneficiary Profile** to the **local agency within three weeks**. A letter will accompany the profile with instructions to contact the **beneficiary** and/or **the authorize representative**. The **beneficiary or their authorize representative** must physically pick up the profiles.
- c. Prior to releasing the profile, the local **agency** must require proof of identity.
- d. If the **beneficiary or their authorize representative** does not pick up the profiles within 30 days of the agency's contact, the agency should shred the profiles.

4. **Law Enforcement**

Local Law Enforcement officers may ask the fraud investigator for a **beneficiary's** medical information for an investigation. In most cases, medical information may not be released without a court order. Refer these calls to **NC DHHS General Counsel's Office** at (919) 855-4890.

5. **Attorneys**

Attorneys may contact a **local agency** investigator to obtain information on medical claims Medicaid paid on behalf of a **beneficiary** who has been in an accident. Refer the attorney to **DHB's Third Party Recovery** section at (919) 527-7690.

6. All Other Requests

If other requests for profiles are received and this section does not address how to handle the requests, refer the requester to **DHB Office of Compliance and Program Integrity's Call Center at (919) 527-7749.**

D. Information Provided on the Medicaid/NCHC Beneficiary Profile

1. A **Medicaid/NCHC** Profile is produced for each CNDS ID number requested during the date range listed on the [DHB-7063](#).
 - a. It includes a description of the service rendered, date of service, billing provider's number, payment status, amount billed, 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.
 - c. **The Payment Summary page lists the total claims paid by the month of the claim payment for each month in the overpayment period.**
 - d. The **Date of Service Summary** page shows the total claims paid **by the month** the service was rendered for each month in the overpayment period.
 - e. For most Medicaid cases, the overpayment amount is established based on the monthly totals reflected on the **Date of Service Summary** page.
 - f. In cases where the totals on the Provider Summary page and Date of Service page differ, **use the lesser amount of the two.**
2. **Claims Payment History Produced on Beneficiary Profiles**
 - a. **Claim payment history produced on the profile are for the date range requested. For most claims, NCTRACKS retains claims history for 10 years from the date of payment.**
 - b. Certain medical procedures and services have limitation criteria that require that the claim data be retained for a longer period (i.e. once in a lifetime procedures) are retained on the claims system forever.

Claims with limitation criteria are retained for the period required (i.e. dentures, eyeglasses).

3. Profiles include monthly contractual fees paid for beneficiaries with active enrollment such as the per member per month (PMPM) payments for all primary care physicians (PCPs) and capitation fees for Managed Care entities. 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 beneficiary 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 on the SSA BENDEX tab in OVS/OLV of the benefit case.
5. Requesting the Initial Beneficiary 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](#), Corrective Action and Responsibility for Errors, 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 a follow-up profile in the 13th month 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 generated. Refer to X.A.1.a. for procedures to follow if the amount of the overpayment changes.
 - d. The EPI470, Medicaid Profile Follow up Case Management Report, identifies claims for which a follow-up profile must be requested. This NC FAST 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 [DHB-7063](#) to request a beneficiary profile for each beneficiary on the case in which there is a period of ineligibility. Request claim information for each ineligible beneficiary based on the actual months of ineligibility for Medicaid.
2. Determine the amount of claims paid during the period of ineligibility for each ineligible beneficiary. The total for the overpayment period is the sum of the totals shown on the profile's Date of Service Summary pages.

- a. For all Medicaid **beneficiaries** except MQB-B or MQB-E, verify the amount of paid claims on the Date of Service Summary for each ineligible **beneficiary** on the **NC FAST** claim.
- b. For **beneficiaries** that are ineligible for MAABD but eligible for MQB-Q, the Medicare crossover claims and the Part A and B premiums are eligible claims. The overpayment is based on the amount of the non-crossover 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 **beneficiaries**, determine the overpayment based on the Part B premiums paid by Medicaid during the period of ineligibility **shown on the SSA Bendex data on the OVS/OLV for the eligibility case for the year(s) in question.**
- f. Refer to VIII. D. and F., above, to determine the overpayment in an LTC case.

F. How to Read Medicaid **Beneficiary Profiles**

1. **Beneficiary Profile Page Header and Claim Header**

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

Profiles are generated during provider Checkwrite. Claims listed on profile were adjudicated prior to or during the checkwrite.

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 08/08/9999
PAYER: DHB	NCTRACKS	PROCESS TIME: 99:99:99
	AS OF: 08/11/9999	PAGE: 999
RECIPIENT HISTORY PROFILE REPORT		
RECIPIENT (123456789Q)	CURRENT PROFILE PG- 1	
REQ BY CLERK=C999JDOE	REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMN	DATES=06/01/9999 07/31/9999
BASE ID=009999999	GENDER=M NAME=SMITH, JOHN	HIC 123456789A MBI DOB=02/15/9999 DOD=
-----CLAIM-----	PROV NBR ATTN NBR PS ADM-FIN DTE AT AH DH BILLED	PAT-LIAB SPEND-DWN PAYABLE NET-PD
C TCN S B	AUTHORIZATION DIAG DESC	DIAG DESC DIAG DESC
T FIN PAYER T R D-----		
T ST FROM-DATE-TO PL QTY PROC TOOTH NBR SURFSRV IM EOB BILLED	REIM CO-PAY OTH-INS	PAID
L PGP PAC MODIFIERS	DESC	PCT

2. **Claim Page Header Description (Lines 1-9)**

FR66200-R0010	The report number used internally to identify reports to the system and to the users
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS	The owner and name of the system from which the claims were retrieved
PROCESS DATE	Date the profile was generated. (Format is in MM/DD/YYYY)
PAYER	Denotes the Division's budget from which the claims listed are paid
AS OF DATE	The Checkwrite date for claim paid during this payment cycle
PAGE	The page number within the entire job of profile requests generated during the Checkwrite
BENEFICIARY	The CNDS ID number for which claims are requested.
CURRENT OR PURGED PROFILE PG	Indicates the type of profile requested and the page number within the beneficiary's profile
REQ BY CLERK	The clerk ID for whom the profile is produced (C plus the local agency's 3-digit agency number, first initial and first three letters of the requestor's last name.)
REQ FOR	This information determines the type of records presented. Defaults to ALL. Prov = If ALL, all providers selected Claim Type = If ALL, all claim types are selected Dates = The range of dates of services requested.
BASE ID	The unique number assigned to the beneficiary in NCTRACKS
GENDER	The gender of the beneficiary
NAME	The name of the beneficiary in the eligibility file on the date the profile was produced
HIC	Health Insurance Claim number
MBI	Medicare Beneficiary Identifier (Only displays for beneficiary who have Medicare)
DOB	The date of birth of the beneficiary
DOD	The death date of the beneficiary, if applicable
CT	Claim type
TCN	Transaction Control Number (aka Claim number) assigned by NCTRACKS
ST	The status of the claim (Header)
PROV NBR	Provider Number for the Billing Provider
ATTN NBR	Provider Number for the Provider who rendered service(s)
ADM-FIN DTE	Date provider was paid
BILLED	The total amount billed on the claim by the provider
PAT-LIAB	The patient liability for this claim
SPEND -DWN	The amount of spend-down (deductible balance) for this claim
NET-PD	The amount paid on this claim by Medicaid
DIAG DESC	The diagnosis number and description

3. Provider Summary Information

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

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 08/08/9999		
PAYER: DHB	NCTRACKS	PROCESS TIME: 99:99:99		
	AS OF: 08/11/9999	PAGE: 9999		
RECIPIENT HISTORY PROFILE REPORT				
RECIPIENT (123456789Q)	PROFILE PG- 14			
REQ BY CLERK=X104 REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNPOQRSTUVWXYZ DATES=06/01/9999 07/31/9999				
BASE ID=009999999 GENDER=M NAME=SMITH, JOHN HIC 123456789A MBI DOB=02/15/9999 DOD=				
PROVIDER SUMMARY INFORMATION				
PROVIDER NUMBER	PROVIDER NAME	NUMBER SERVICES	AMOUNT BILLED	AMOUNT PAID
1437167673	MCLEOD ADDICTIVE DIS	10	726.30	726.30
1588903322	VAYA HEALTH	9	336.58	336.58
1821376542	MCDOWELL HOSPITAL IN	7	17.50	17.50
1912903717	DOMINION DIAGNOSTICS	1	250.00	72.75
6701007	NORTH CAROLINA COMMU	7	30.31	30.31
6704000	MEDSOLUTIONS INC	7	54.32	54.32
TOTAL		41	1,415.01	1237.76

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 Enrollment File
NUMBER SERVICES	Number of services is calculated by accumulating the quantity fields on most claims type. 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

4. **Payment Summary**

The Payment Summary provides a monthly summary of paid claim information for the Medicaid **beneficiary**. The summary provides the amounts paid for the period requested based on the **month of payment**. This report is produced at the same time as the Claims Information and the Provider Summary Information.

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 08/08/9999
PAYER: DHB	NCTRACKS	PROCESS TIME: 99:99:99
	AS OF: 08/11/9999	PAGE: 9999
RECIPIENT HISTORY PROFILE REPORT		
RECIPIENT (123456789Q)	PROFILE PG- 15	
REQ BY CLERK=X104 REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNOPQRSTUVWXYZ DATES=06/01/9999 07/31/9999		
BASE ID=009999999	GENDER=M NAME=SMITH, JOHN	HIC 123456789A MBI DOB=02/15/9999 DOD=
PAYMENT SUMMARY		
	PAID DATE	AMOUNT BILLED
		AMOUNT PAID
	01/2019	206.64
	02/2019	134.01
	03/2019	206.64
	04/2019	206.64
	05/2019	134.01
	06/2019	134.01
	07/2019	311.38
	08/2019	72.63
	10/2019	9.05
	TOTAL	1,415.01
		1,237.76

PAID DATE	The month in which the payments were paid.
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.

5. **Date of Service Summary**

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

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 08/08/9999	
PAYER: DHB	NCTRACKS	PROCESS TIME: 99:99:99	
	AS OF: 08/11/9999	PAGE: 9999	
RECIPIENT HISTORY PROFILE REPORT			
RECIPIENT (123456789Q)	PROFILE PG- 16		
REQ BY CLERK=X104 REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNOPQRSTUVWXYZ DATES=06/01/9999 07/31/9999			
BASE ID=009999999	GENDER=M NAME=SMITH, JOHN	HIC 123456789A MBI DOB=02/15/9999 DOD=	
DATE OF SERVICE SUMMARY			
	PAID DATE	AMOUNT BILLED	AMOUNT PAID
	01/2019	206.64	206.64
	02/2019	206.64	206.64
	03/2019	206.64	206.64
	04/2019	134.01	134.01
	05/2019	134.01	134.01
	06/2019	384.01	206.76
	07/2019	143.06	143.06
	TOTAL	1,415.01	1,237.76

PAID DATE	The month in which the payments were paid.
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. **Cross Reference ID Summary**

The Cross-Reference ID Summary provides all ID numbers assigned to **beneficiary** that have been merged. Any claims filed under these ID numbers will appear on the profile for the dates of service requested.

Any ID numbers the **beneficiary** has that have not been merged will not display. A separate profile will need to be submitted for these ID numbers.

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 08/08/9999
PAYER: DHB	NCTRACKS	PROCESS TIME: 99:99:99
	AS OF: 08/11/9999	PAGE: 9999
RECIPIENT HISTORY PROFILE REPORT		
RECIPIENT (123456789Q)	PROFILE PG- 17	
REQ BY CLERK=X104 REQ FOR PROV=ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNPOQRSTUVWXYZ DATES=06/01/9999 07/31/9999		
BASE ID=009999999 GENDER=M NAME=SMITH, JOHN HIC 123456789A MBI DOB=02/15/9999 DOD=		
CROSS REFERENCE ID SUMMARY		
ALT ID	BASE ID	CROSS REFERENCE ID STATUS
999999999Q	009999999	A

ALT ID	Lists all IDs beneficiary has that have been assigned and merged.
BASE ID	The unique number assigned to the beneficiary in NCTRACKS .
CROSS REFERENCE ID STATUS	The status of the ID number. The four available statuses are: A - Active; C- Closed; M- Merged; S -Soft Delete; V- Void

7. Claim Type Codes

CLAIM TYPE	DESCRIPTION
A	Medicare Part A Crossover (Inpatient)
B	Medicare Part B Crossover (Professional)
C	Health Departments
D	Dental
E	Hearing Aid
F	Nursing Home
G	Hospice
H	Home Health
I	Inpatient
K	Private Duty Nursing
L	Independent Laboratory / Xray
M	Management Fee
N	Adult Care Homes
O	Outpatient
P	Professional
Q	Mental Health
R	Drug
S	Durable Medical Equipment
T	Ambulance (Professional)/Non-Emergency Medical Transportation
U	Medicare Part B Crossover UB (Outpatient)
V	Children's Developmental Services Agencies
W	Financial Claim
X	Optical
Y	Undefined Professional
Z	Undefined Institutional
0	Local Education Agencies
1	Home Infusion Therapy
2	Therapy Services
3	Institutional Ambulance
4	Capitation
5	Rural Health Clinic / Federally Qualified Health Center
6	Personal Care Services
8	Independent Diagnostic Testing Facility / Portable Xray
9	Maternity Event

8. **Claim Status Codes**

CLAIM STATUS	DESCRIPTION OF CODE	COUNTABLE OR NOT COUNTABLE
A	Awaiting Fund Availability	Count
C	To Be Denied	Do Not Count
D	Denied	Do Not Count
O	To Be Paid	Count
P	Paid	Count
S	Pending	Do Not Count

G. How to Determine the Service Code for NC FAST

1. Use the **Provider Summary** Information from the **beneficiary** profile to determine the provider number with the highest paid amount. Use the service code for this provider claim type when keying **NC FAST** 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 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 code on the **NC FAST** claim.
3. **Medicaid Service Codes**

SERVICE CODE	CLAIM TYPE	DESCRIPTION
01	A, I, 3	Medicare Part A Crossover (Inpatient)/Inpatient Hospital, Institutional Ambulance (Emergency Transportation)
02	O, U	Medicare Part B Crossover UB (Outpatient)/Outpatient Hospital
03	D	Dental
04	R	Drugs
05	B, C, L, M, P, Q, V, X, Y, 0, 2, 4, 5,8	Medicare Part B Crossover (Professional), Health Depts, Labs/X-Rays, Management Fee, Professional, Mental Health, Children's Developmental Services Agencies, Optical, Undefined Professional, Local Education Agencies, Therapy Services, Capitation Fee/Rural Health Clinic/Federally Qualified Health Center/ Independent Diagnostic Testing Facility/Portable X-Ray
06	G, H, K, S, 1, 6, E	Hospice, Home Health, Personal Care Services
09	N/A	Medicare Premium (Not found on Beneficiary Profiles)
11	F, N	Nursing Home (SNF, ICF) & Personal Care Services in Adult Care Home
67	N/A	NC Health Choice
71	T	Ambulance (Professional), Non- Emergency Medical Transportation

H. Examples of Claim Types and Claim Status Codes

- The following are examples of the Claim Detail Information for various Claim Types.

a. Examples: Claim Types M and 4 (Management and Capitation Fees)

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 08/08/9999
PAYER: DHB	NCTRACKS	PROCESS TIME: 99:99:99
	AS OF: 08/11/9999	PAGE: 999
RECIPIENT HISTORY PROFILE REPORT		
RECIPIENT (123456789Q)	CURRENT PROFILE PG- 84	
REQ BY CLERK=C999JDOE	REQ FOR PROV= ALL	CLAIM TYPE = 012345689ABCDEFGHIJKLMNQRSTUUVWXYZ
DATES=06/01/9999	07/31/9999	
BASE ID=009999999	GENDER=M	NAME=SMITH, JOHN
HIC 123456789A	MBI	DOB=02/15/9999
DOD=		
-----CLAIM-----	PROV NBR	ATTN NBR
C TCN	S B AUTHORIZATION	DIAG DESC
T FIN PAYER T R D	PS ADM-FIN DTE AT AH DH	BILLED PAT-LIAB SPEND-DWN
	DIAG DESC	DIAG DESC
	T ST FROM-DATE-TO PL QTY PROC TOOTH NBR SURFSRV IM	EOB BILLED REIM CO-PAY OTH-INS
	L PGP PAC MODIFIERS	DESC PCT
M 1111111111110000	P N 6701006	010399
BILLING NPI	BILL TXNMY 305R00000X	ATTN NPI 1407133069
DHB CK=		ATTN TXNMY 193200000X
EL DAYS		
	001 P 010199 013199	1.000
MCAID		00
		4.33 .00 .00
		.0000 COS=0120
		.00 .00 .00
		4.33
		4.33
		ICD VER
		ICD VER
4 2222222222220000	P N 6704000	6704000
BILLING NPI	BILL TXNMY 302R00000X	010399
DHB CK=		ATTN NPI
EL DAYS		ATTN TXNMY 302R00000X
	001 P 010199 013199	1.000
MCAID		00
		7.76 .00 .00
		.0000 COS=
		.00 .00 .00
		7.76
		7.76
		ICD VER
		ICD VER

C	Claim type
T	
TCN	Transaction Control Number (aka Claim Number)
FROM-DOS-TO DOS	The from and thru dates of service of Line Items(s)
S	Status of claim (Header)
T	
NET-PD	The amount Medicaid paid on this claim
DIAG DESC	The diagnosis description (If the diagnosis code billed is invalid, no description will be displayed)
BILLED	The amount billed to NC Medicaid
NET PD	The amount Medicaid paid for this claim.
LINES 01-XX	Breakdown of Medicaid claim into Line Items (Medicaid Claim Line item 001 is displayed in example)
ST	Status of claim for Line Item(s)

b. Examples- Claim Type R and P (Drug and Professional)

Drug claims only show the actual date of service. The date of service is the day the prescription is filled.

Professional claims have a “From and To Date of Service”.

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 08/08/9999
PAYER: DHB	NCTRACKS	PROCESS TIME: 99:99:99
	AS OF: 08/11/9999	PAGE: 1005
RECIPIENT HISTORY PROFILE REPORT		
RECIPIENT (123456789Q)	CURRENT PROFILE PG- 90	
REQ BY CLERK=C999JDOE	REQ FOR PROV= ALL	CLAIM TYPE = 012345689ABCDEFGHIKLMNOPQRSTUVWXYZ
DATES=06/01/9999	07/31/9999	
BASE ID=009999999	GENDER=M	NAME=SMITH, JOHN
HIC 123456789A	MBI	DOB=02/15/9999
DOD=		
-----CLAIM-----	PROV NBR	ATTN NBR
PS ADM-FIN DTE AT AH DH BILLED	PAT-LIAB	SPEND-DWN
PAYABLE	NET-PD	
CT TCN	ST B AUTHORIZATION	DIAG DESC
DIAG DESC	DIAG DESC	DIAG DESC
FIN PAYER	R D-----	
T	ST FROM-DATE-TO	PL QTY PROC TOOTH NBR SURFSRV IM
EOB BILLED	REIM	CO-PAY
OTH-INS	PAID	
L PGP PAC	MODIFIERS	DESC
PCT		
R 333333333330000 P	00125701	013099
15.99		11.80
11.80		
BILLING NPI 1861595613	BILL TXNMY	
DHB CK=999999999	PRESC=000001111111	ICD VER 0
001 P 012299	0 21.000	15.99
.00 3.00 .00	11.80	
GEN 39802	GCN 009043	DAYS SUPP 7
NDC 68180012202	DESC CEPHALEXIN 500 MG CAPSULE	
P 888888888840000 P	N	061820
2160.00	.00	.00
1103.07		1103.07
BILLING NPI 1639506470	BILL TXNMY 193200000X	ATTN NPI 1700261260
ATTN TXNMY 363LW0102X		
DHB CK=	Z30433	ENCNTR FOR REMOVAL
EL DAYS		ICD VER 0
		ICD VER
001 P 020520 020520	11 1.000 58301 00 N@3	350.00
72.62	.00	.00
72.62		
MCAID 4 FP	REMOVE INTRAUTERINE DEVICE	.0000
COS=2680		
002 P 020520 020520	11 1.000 58300 00 N@3	350.00
59.14	.00	.00
59.14		
MCAID 4 FP	INSERT INTRAUTERINE DEVICE	.0000
COS=		
003 P 020520 020520	11 1.000 81025 00 N@3	30.00
7.80	.00	.00
7.80		
MCAID 4 FP	URINE PREGNANCY TEST	.0000
COS=		
004 P 020520 020520	11 1.000 J7298 00 N@3	1430.00
963.50	.00	.00
963.51		
MCAID FP	LEVONORGESTREL IU 52MG 5 YR	.0000
COS=		

C	Claim type
T	
FROM-DOS-TO DOS	The from and thru dates of service of Line Item(s) (For drug claims, this is the date the prescription is filled)
S	Status of claim (Header)
T	
NET-PD	The amount Medicaid paid on this claim
DIAG DESC	The diagnosis description (If the diagnosis code billed is invalid, no description will print)
DAYS SUPP	The number of days the prescription covers
NDC	National Drug Code (Drug claims only)
DESC	Name of prescription drug (Drug Claims only)
LINES 001-XXX	Breakdown of the Medicaid Claim into to Line Items (Lines 001-004 in example).
ST	Status of claim for Line Item(s)
FP	The internal modifier required on Family Planning claims.

c. Example - Claim Types F and I (Nursing Home and Inpatient Hospital)

1. Claim Type F (Nursing Home)

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

Refer to F.2., above, for claims header information

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 08/08/9999
PAYER: DHB	NCTRACKS	PROCESS TIME: 99:99:99
	AS OF: 08/11/9999	PAGE: 1006
RECIPIENT HISTORY PROFILE REPORT		
RECIPIENT (123456789Q)	CURRENT PROFILE PG- 91	
REQ BY CLERK=C9999DOE REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNPOQRSTUVWXYZ DATES=06/01/9999 07/31/9999		
BASE ID=009999999	GENDER=M NAME=SMITH, JOHN	HIC 123456789A MBI DOB=02/15/9999 DOD=
-----CLAIM-----	PROV NBR ATTN NBR PS ADM-FIN DTE AT AH DH BILLED PAT-LIAB SPEND-DWN PAYABLE NET-PD	
CT TCN ST B AUTHORIZATION	DIAG DESC DIAG DESC DIAG DESC	
FIN PAYER RD-----		
T ST FROM-DATE-TO	PL QTY PROC TOOTH NBR SURFSRV IM EOB BILLED REIM CO-PAY OTH-INS PAID	
L PGP PAC MODIFIERS	DESC PCT	
F 5555555555500000P N	30 031020 3 15 789.00 .00 .00 611.13 611.13	
BILLING NPI 1235370750	BILL TXNMY 314000000X ATTN NPI ATTN TXNMY	
DHB CK=200310035		ICD VER
EL DAYS		ICD VER
MCRD=10000974	PCP= PI= ADMIT DIAG I5023 COV= 3 NONCOV= 0	
PROC CODES/DATES		
COND CODES D7		
OCCUR CODES/DATES		
VALUE CODES/AMOUNTS 23	80 3.00	
001 P 022720 022720	31 3.000 0120 00 N@A 789.00 203.71 .00 .00 611.13	
MCAID	ROOM & BOARD-SEMI-PRIV GEN CLASS .0000 COS=0035	

C	Claim type
T	
S	Status of claim (Header)
T	
NET-PD	The amount Medicaid paid on this claim.
LINES 01-XX	Breakdown of Medicaid claim into Line Items (Medicaid Claim Line items 001 is displayed in example)
ST	Status of claim for Line Item(s).
FROM-DOS-TO DOS	The from and thru dates of service.
DESC	The description of procedure of service rendered.

2. Claim Type I (Inpatient Hospital)

Hospital Claims are paid based on the Diagnosis Related Grouping (DRG) rate no matter how many days a **beneficiary** is in the hospital.

Refer to F.2., above, for claims header information.

-----CLAIM-----	PROV NBR	ATTN NBR	PS ADM-FIN DTE AT AH DH BILLED	PAT-LIAB SPEND-DWN	PAYABLE	NET-PD			
CT TCN	ST B AUTHORIZATION	DIAG DESC	DIAG DESC	DIAG DESC					
FIN PAYER	RD	-----							
T ST FROM-DATE-TO PL QTY PROC TOOTH NBR SURFSRV IM	EOB BILLED	REIM	CO-PAY	OTH-INS	PAID				
L PGP PAC MODIFIERS	DESC	PCT							
I 888888888840000	P N		01 072818 081418 2 05 13	7588.84	.00	.00	81.52	1881.52	
BILLING NPI 1801823349	BILL TXNMY 282N00000X		ATTN NPI	ATTN TXNMY					
DHB CK=180814122		Z370	SINGLE LIVE BIRTH	Z3A36	36 WEEKS GESTATION			ICD VER 0	
EL DAYS								ICD VER	
MCRD=000000531056		PCP=	PI=	ADMIT DIAG	O6010X0	COV= 1	NONCOV= 0		
PROC CODES/DATES 10E0XZZ	07281								
DRG 0775	ALOS 2.0	WEIGHT	.6957	DRG VER 35	DRG AMT	1881.52			
DIAG O6014X0	PROC	OUTLIER=		OUTL R AMT	.00				
COND CODES 39									
OCCUR CODES/DATES A1	020493								
VALUE CODES/AMOUNTS 01	1547.00	80	1.00	A3	7588.84				
001 P 072899 072999	21	1.000 0112	00	N @A	885.00	2704.50	.00	.00	1881.52
MCAID		ROOM AND BOARD-PRIVATE OB			.0000	COS=0015			
002 D 072899 072999	21	2.000 0250	00	N @B 09271	707.16	.00	.00	.00	.00
MCAID		PHARMACY-GEN CLASS		.0000	COS=0015				
003 D 072899 072999	21	5.000 0270	00	N @B 09271	290.19	.00	.00	.00	.00
MCAID		MED/SURG SUPPLIES & DEVICES-GEN CLASS		.0000	COS=0015				
004 D 072899 072999	21	8.000 0300	00	N @B 09271	965.95	.00	.00	.00	.00
MCAID		LAB-GEN CLASSIFICATION		.0000	COS=0015				
005 D 072899 072999	21	3.000 0710	00	N @B 09271	2110.32	.00	.00	.00	.00
MCAID		RECOVERY ROOM-GEN CLASS		.0000	COS=0015				
006 D 072899 072999	21	4.000 0720	00	N @B 09271	2,630.22	.00	.00	.00	.00
MCAID		LABOR ROOM/DELIVERY-GEN CLASS		.0000	COS=0015				

C	Claim type
T	
S	Status of claim (Header)
T	
NET-PAY	The amount Medicaid paid on this claim
DESC	Procedure code and description of procedure or service rendered
LINES 01-XX	Breakdown of Medicaid claim into Line Items (Medicaid Claim Line items 001 -0006 are displayed in example)
ST	Status of claim for Line Item(s)
FROM-DOS-TO DOS	The from and thru dates of service for Line Item(s)

d. **Examples - Crossover Claims (Claim type B and U)**

Crossover information is presented on claims, which have crossed over from Medicare for payment of the Medicare coinsurance and/or deductible by Medicaid.

The example below begins at the claim header. Profile header not included.

Refer to F.2., above, for claims header information

-----CLAIM-----	PROV NBR	ATTN NBR	PS ADM-FIN DTE	AT AH DH BILLED	PAT-LIAB SPEND-DWN	PAYABLE	NET-PD				
CT TCN	ST B AUTHORIZATION	DIAG DESC	DIAG DESC	DIAG DESC	DIAG DESC						
FIN PAYER	R D	-----									
T	ST FROM-DATE-TO	PL QTY	PROC TOOTH	NBR SURFSRV	IM EOB	BILLED	REIM	CO-PAY	OTH-INS	PAID	
L	PGP PAC	MODIFIERS	DESC	PCT							
B 4444444444400000	P N			061199		615.00	.00	.00		16.15	16.15
BILLING NPI 1942440375 BILL TXNMY 193200000X ATTN NPI 1578705745 ATTN TXNMY 207RP1001X											
MCARE DEDUCT IND=M MCARE TPL AMT= 173.81 OTHER TPL AMT= 173.81 EST AMT DUE= .00											
DHB CK=999999999	J9621	ACUTE AND CHRONIC	I5023	ACUTE ON CHRONIC S F339						MAJOR DEPRESSIVE D ICD VER 0	
EL DAYS	J9622	ACUTE AND CHRONIC								ICD VER 0	
MCRD=ZZZZZZ PCP= PI= ADMIT DIAG COV= 0 NONCOV= 0											
XOVER ICN=999999999999	PAY-DTE=	TOT-BILL=	615.00	TOT-DED=	.00	COINS=	42.00	TOT-PAY=	173.81		
FDOS=050819	IDOS=050819	EOB=	TOT-OTHER-INS=	173.81	MCARE PROV =	0001	PSY-RED=	.00			
001 P 050819 050819	21	1.000	99291	@3		615.00	189.96	.00	173.81	16.15	
MCAID 4	##	CRITICAL CARE FIRST HOUR				.0000	COS=1390				
U 5555555555500000	P N			01 010101 040219	3	599.00	.00	.00		.00	.00
BILLING NPI 1013916352 BILL TXNMY 282N00000X ATTN NPI ATTN TXNMY											
MCARE DEDUCT IND=M MCARE TPL AMT= 88.23 OTHER TPL AMT= 42.36 EST AMT DUE= .00											
DHB CK=999999999	F1190	OPIOID USE, UNSPEC C20		MALIGNANT NEOPLASM R109						UNSPECIFIED ABDOMI ICD VER 0	
EL DAYS	G8929	OTHER CHRONIC PAIN F329		MAJOR DEPRESSIVE D R102						PELVIC AND PERINEA ICD VER 0	
MCRD=ZZZZZZ PCP= PI= ADMIT DIAG COV= 0 NONCOV= 0											
COND CODES											
OCCUR CODES/DATES											
VALUE CODES/AMOUNTS B3 22.51											
001 D 030799 030799	22	1.000	0301 00	N@3 01760		243.00	72.63	.00	42.36	.00	
MCAID		LAB-CHEMISTRY				.0000	COS=0016				
002 P 030799 030799	22	1.000	0510 00	N@3		356.00	.00	.00	.00	.00	
MCAID		CLINIC-GEN CLASS				.0000	COS=0016				

C	Claim type
TCN	Transaction Control Number (Medicaid claim number)
FROM-DOS-TO DOS	The from and thru dates of service for Line Item(s)
S	Status of claim (Header)
T	
NET-PAY	The amount Medicaid paid on this claim
MCARE TPL AMT	Medicare payment amount
OTHER TPL AMT	Other private insurance payment
XOVER ICN	Indicates Medicare crossover and claim number
PAY DATE	Date Medicare paid claim if present on claim
TOT BILL	Amount billed to Medicare
TOT-DED	Total Medicare Deductible
COINS	Coinsurance (20% not paid by Medicare)
TOT-PAY	The Medicare Payment
LINES 01-XX	Breakdown of Medicare Claim into Line Items (Medicare Claim Line items 001 and/or 002 are displayed above)
ST	Status of claim for Line Item(s)

XVII. CITATIONS AND REFERENCES

Social Security Act, Title XIX, Section 1909
42 CFR 455 "Program Integrity"
Social Security Act 1137, 435.940ff
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