Alabama Medicaid Agency

Improper Payment Review

June 2013

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► **Agenda**
- Approach and overview
- Improper payment types
- Process

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► **Approach and Overview**

- Project Goals
  - To ensure the Alabama Medicaid Agency is the payer of last resort as required by the Code of Federal Regulations Chapter 42
  - To identify improperly billed/paid claims
- Methodology
  - Perform a comprehensive review of all financial related activity for each Medicaid eligible resident in the facility for the review period
  - Review financial documentation including facility census, aged trial balance report, detailed financial history reports, and other relevant financial documentation as required
  - Potential improper payments are identified through a comparative analysis of the facility's records, Medicaid claims payment history and eligibility data.

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► **Improper Payment Types**

- Resident Available Monthly Income – Overpayments
  - Increases in social security, pensions, and other income collected by the facility but not reflected on the eligibility system and/or claim
  - Income diversion/deduction overpayments
  - Identification of unapplied resident available monthly income
  - Lump sum income payments made to the facility not reported to the Alabama Medicaid Agency
- Claims (Room & Board/Coinsurance) – Overpayments
  - COB review to ensure the Alabama Medicaid Agency is the payer of last resort
  - Duplicate and overlapping payments
  - Disallowed coinsurance payments
  - Payments made the date of discharge/death and beyond
  - Review of pre-eligibility private payment period
  - Disallowed therapeutic leave bed reservation payments

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► **Provider Notification**

- Introductory letter sent to providers from the Alabama Medicaid Agency
- Entrance conference scheduled and conducted by HMS with administrator and/or financial office staff
- Required financial documentation obtained from the provider
- Desk review performed at HMS office in order to minimize the disruption to LTC facility staff

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► **Improper Payment Review Documentation**

- Complete facility census report
  - Must include all payer classes
  - Must be run for the entire review period
  - Must detail all admissions, discharges, changes in payer classes
- Current aged trail balance report
  - Must include all payer classes
  - Must be run as of the current date or the last month closed
- Detailed paper or electronic financial history report for each Medicaid recipient for the review period
  - Must include all payer classes
  - Must be run through the current date to ensure all financial activity effecting the review period is included
  - Must be supplied for each Medicaid resident who resided at the facility during the review period regardless of whether the resident is currently in house, discharged, or deceased.

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► **Process Overview**

- Review performed and potential improper payments identified
- Initial findings reported to provider
  - Provider will receive two reports, a Resident Available Monthly Income Overpayment Report, and a Claims Overpayment Report
  - Provider will have 30 days to review the reports and respond
- Provider response received and reviewed by HMS
  - If necessary, the provider will receive a second set of reports called the "Needs More Information" Reports
  - Provider will have 14 days to review and respond

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► **Process Overview (cont)**

- Final Improper Payment Review Report
  - Once the second response is received from the provider and reviewed, HMS will send the provider a Final Improper Payment Review Report detailing all recoveries/refunds to be initiated as a result of the review
  - Both resident available monthly income and claim improper payments will be included on the report
  - Provider has 10 days to review the report and contact HMS to set up an exit conference if desired.
- Final Improper Payment Review Report submitted to Alabama Medicaid Agency along with all appropriate recovery documentation

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For additional questions please contact:

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