
Medicaid Status Changes Submission Process and SOPs

Overview:

Organizations must submit requests to the Retroactive Processing Contractor (Reed & Associates and IntegriGuard) either electronically on a CD or diskette. The specific format and required fields for submission of the retroactive status changes for the Medicaid status changes is addressed below. The electronic submission process is outlined at the end of this document. Please note that this information cannot be sent by e-mail as required under HIPAA regulations. A cover letter including the organization number (H#, S#, R#) and certification must be submitted along with the requested changes. An example of appropriate language for the certification is as follows:

“This signature verifies that the information submitted to the Retroactive Processing Contractor on (date) is accurate and complete and that supporting documentation is being maintained at the organization for each request.”

The organization must retain original supporting documentation for requested changes as it may be required to produce it during a Government audit at a later date.

Submitting Medicaid Status Changes

This applies to MAs, MA-PDs, Demonstrations, and PACE Organizations
The organization will submit its requested changes to the Retroactive Processing Contractor. Requested changes will be processed within 45 days of receipt. Upon completion of processing, the Retroactive Processing Contractor will provide the organization with a report detailing the disposition of the requests. Supporting documentation will be required as requested by the Retroactive Processing Contractor in conjunction with the probe study (see section below titled “Probe Study”).

The information and column order needed to process each Medicaid status change is as follows:

Organization Name				Contact Name:				
Mailing Address				Phone #:				
City, State, Zip Code				E-Mail Address:				
City, State, Zip Code				E-Mail Address:				
Medicaid								
H#	CMS Region #	HIC #	Beneficiary's Last Name	Beneficiary's First Name	Verified From mm/yyyy	Period Date	Verified Thru mm/yyyy	Period Date

Please note: The “Verified Beginning Date” is defined as the start date of the period for which you are requesting payment at the Medicaid rate. The “Verified Ending Date” is defined as the end date of the period for which you are requesting payment at the Medicaid rate. If the organization does not have the thru date because the beneficiary still qualifies for Medicaid status, then leave the Verified Ending Date field blank.

Submitting the Removal of Medicaid Status Changes

This applies to MAs, MA-PDs, Demonstrations, PACE Plans

The organization will submit its requested changes to the Retroactive Processing Contractor. Requested changes will be processed within 45 days of receipt. Upon completion of processing, the Retroactive Processing Contractor will provide the organization with a report detailing the disposition of the requests. Supporting documentation will be required as requested by the Retroactive Processing Contractor in conjunction with the probe study (see section below titled “Probe Study”).

The information and column order needed to process removal of Medicaid status is as follows:

Organization Name				Contact Name:			
Mailing Address				Phone #:			
City, State, Zip Code				E-Mail Address:			
Medicaid Removal							
H#	CMS Region #	HIC #	Beneficiary's Last Name	Beneficiary's First Name	Beginning Month mm/yyyy	Ending Month mm/yyyy	

Please note: The “Beginning Month” field is defined as the start date of the period for which you are requesting the Medicaid payment rate be removed. The “Ending Month”

field is defined as the end date of the period for which you are requesting the Medicaid payment rate be removed. The Medicaid payment rate will be removed through the last day of this month. All fields must be completed.

Electronic Submission Data Field Specifications and Instructions

Organizations must submit retroactive payment adjustment requests electronically using a formatted spreadsheet developed by the Retroactive Processing Contractor. Organizations can request a copy of this spreadsheet directly from the Retroactive Processing Contractor or it can be downloaded from its web site, www.integriguard.org. This spreadsheet has been developed using visual basic code to assist you in making sure that the data is being submitted in the appropriate format. In order to take advantage of this coding, it is necessary to click on the “Enable Macros” button when opening the spreadsheet. A pop up box will appear when the file is opened which will indicate that the file contains macros. If you elect to “Enable Macros,” then you will be able to use the “validate” button. Once pressed, this button runs a program that checks your entire spreadsheet for incorrect entries based on the programming allowed for that cell. If you elect to “Disable Macros,” you will still be able to utilize this spreadsheet to submit your requests to the Retroactive Processing Contractor, but the validation process will not be functional.

The specifications for each data field are as follows:

1. Data specifications for fields that are common to all spreadsheets

H Number:	Format as a text field. Field is limited to 5 characters
Region:	Format as a text field. Field is limited to 2 characters and primary numbers
HIC:	Format as a text field. Field is limited to 15 characters
Last_Name:	Format as a text field. Field is limited to 20 characters
First_Name:	Format as a text field. Field is limited to 20 characters

2. Data specifications for fields specific to the Medicaid status category

Ver_Beg_Date:	Format as a date field and enter the start date as 03/01/1998
Ver_End_Date:	Format as a date field and enter the end date as 03/31/1998

3. Acceptable Excel Versions:

Microsoft Excel 97-2000

Microsoft Excel 2003

Probe Study

In order to assure appropriate oversight, the Retroactive Processing Contractor will periodically conduct a probe study by requesting supporting documentation from various organizations. The purpose of these studies is to review and verify that appropriate documentation is maintained by the organization as defined by CMS. The Standard Operating Procedures (SOP) are a tool that may assist the organizations in identifying the necessary documentation.

A five percent random sample of organization status changes will be chosen for inclusion in the study. When an organization is notified of inclusion in the probe study, the organization will have 7 business days from the date of the Retroactive Processing Contractor's request to submit supporting documentation. After review of the documentation, the Retroactive Processing Contractor will send the organization a report of the findings. If the documentation is not received or does not support the requested changes, the changes will be nullified. A report will be sent to the organization and to CMS detailing this action.

Submission Address

Please send all payment adjustment requests for changes to status categories noted above to:

IntegriGuard
Attention: Health Status Category Changes
2121 North 117 Avenue, Suite 200
Omaha, NE 68164
Phone: 402.955.2781
Fax: 402.955.2789

60.3 - Standard Operating Procedures for Medicaid Retroactive Adjustments (Rev. 46, 02-13-04)

Medicaid Description

This applies to MAs, MA-PDs, Demonstrations, and PACE

Medicaid is a Federal and state program that provides medical services to low-income families, children and pregnant women as well as to low-income aged, blind and disabled individuals. Medicaid eligibility is determined by the State Medicaid Agency in the state where the beneficiary resides. Some Medicare beneficiaries are also eligible for Medicaid. These individuals are commonly referred to as Dual Eligible beneficiaries. The Centers for Medicare & Medicaid Services (CMS) administers the federal standards compliance aspects of this program and monitors the federal payments related to the Medicaid program for both Medicaid only and the dually eligible population. The law requires that all states pay the Part B premium to Medicare for certain dual eligible beneficiaries (i.e., those eligible for Medicare as a Qualified Medicare Beneficiary, a Special Low-Income Medicare Beneficiary or a Qualifying Individual). The law does not require states to pay the Part B premium for individuals who are classified as Medical Assistance Only (MAO) even though the increased capitation rate applies, however, many states have elected to report these individuals as dually eligible and pay their Part B premium.

General Information About Medicaid Payments

In accordance with the Health Status hierarchy (Hospice, ESRD, Working Aged, Institutional, Medicaid), organizations receive a higher capitation rate for Medicare beneficiaries who have been identified as Medicaid in the CMS systems.

The primary source of this information is the Third Party Master Premium Billing system (TPM), which is used by CMS to bill states for the Part B premiums paid by states on behalf of dually eligible individuals. All states report data in this system as all states pay the Part B premium for their dual eligible (with the exception of MAOs in some states). This is the source data used by the managed care payment system to identify the dually eligible beneficiaries that have Medicaid status. The organizations are required to rely on the data from the TPM billing system for this portion of the population. The TPM records this transaction. The managed care payment system then interfaces monthly with the TPM and updates its files to reflect any new information. This process may effect payments prospectively and retroactively. The organization should notify the state office responsible for updating the CMS Third Party Billing system when discrepancies are identified for dually eligible individuals.

Guidelines for Prospective Medicaid Adjustments

The organizations can identify beneficiaries as Medicaid in certain instances, for prospective payments only. Primarily this is to place individuals who are classified as Medical Assistance Only (MAOs) in a Medicaid status, but are not limited to this category. These prospective payments are submitted to CMS during the normal monthly process. The organizations need only report the MAO status for members who reside in the states that do not report these individuals. All other dually eligible beneficiaries are reported to CMS via the TPM update process.

General Guidelines for Organizations Requesting Retroactive Adjustments

The organization must submit requests for adjustments to the Retro-Processing Contractor within 45 days of identifying the discrepancy during the normal monthly reconciliation of the CMS Monthly Membership report against the organization's records.

The organization may request a retroactive adjustment either placing a beneficiary into the Medicaid health status or removing the beneficiary from the Medicaid health status.

The organization should never submit duplicate information unless the CMS Central Office or Regional Office or the Retroactive Processing Contractor specifically requests that duplicate information be submitted.

CMS allows the organizations 6 months in which to report discrepancies. Any requests with an effective date of greater than 6 months requires additional documentation to substantiate the requested change and to substantiate the delay in submitting the request.

The six-month period begins from the date the submission is received by the Retroactive Processing Contractor.

To follow up on specific previously submitted requests for adjustments, a letter of inquiry should be sent separately from other requests for adjustments. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, specific action requested, the discrepancy period involved and the date the original request(s) was submitted.

Retroactive Medicaid adjustments will be made for the dates requested, however, payment will be made for no more than 36 months from the date the complete documentation is received by the Retroactive Processing Contractor.

The following chart illustrates the Medicaid programs available for beneficiaries, how beneficiaries qualify, and whether organizations can request Medicaid adjustment for beneficiaries in a particular Medicaid program.

<p>Qualified Medicare Beneficiary (QMB)</p>	<ul style="list-style-type: none"> ➤ Is entitled to Medicare Part A ➤ Individual Monthly Income of \$837 or less ➤ Couple Monthly Income of \$1120 or less ➤ Individual Resources of \$4000 or less ➤ Couple Monthly Resources of \$6000 or less 	<p>YES</p>
<p>Specified Low-Income Medicare Beneficiary (SLMB)</p>	<ul style="list-style-type: none"> ➤ Is entitled to Medicare Part A ➤ Individual Monthly Income of > \$837 < \$1000 ➤ Couple Monthly Income of > \$1120 < \$1340 ➤ Individual Resources of \$4000 or less ➤ Couple Monthly Resources of \$6000 or less 	<p>YES</p>
<p>Qualifying Individual-1 (QI-1)</p>	<ul style="list-style-type: none"> ➤ Is entitled to Medicare Part A ➤ Individual Monthly Income of at least \$1000 but less than \$1123 ➤ Couple Monthly Income of at least \$1340 but less than \$1505 ➤ Individual Resources of \$4000 or less ➤ Couple Monthly Resources of \$6000 or less ➤ Must not be otherwise eligible for Medicaid benefits 	<p>Beginning in 2005</p>

Qualified Disabled and Working Individual (QDWI)	<ul style="list-style-type: none"> ➤ Lost Part A but can purchase Part A benefits when they return to work ➤ Individual Monthly Income of less than \$3353 ➤ Couple Monthly Income of less than \$4485 ➤ Individual Resources of \$4000 or less ➤ Couple Monthly Resources of \$6000 or less ➤ Must not be otherwise eligible for Medicaid benefits 	NO
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Documentation Required to Retroactively Change the Medicaid Health Status of a Beneficiary

- Organization Contract Number (H#)
- Beneficiary Name and Claim Number
- Verification of Medicaid Status including starting/ending dates
- One or more of the following constitutes acceptable documentation
 - A copy of the Medicaid card and documentation that the organization verified Medicaid eligibility with the state including:
 - The date of the verification call by the organization
 - The phone number used to verify eligibility
 - The name of the state staff person who verified the Medicaid period
 - A copy of the state document that confirms Medicaid entitlement for the discrepant period
 - A screen print from the State’s Medicaid System that shows the Medicaid status for the discrepant period

The plan must submit documentation from the state authorizing the use of the Medicaid information for this purpose. If a vendor provides the required information to request a change in the Medicaid status, the organization must submit a document from that state authorizing the use of the vendor as a valid source for Medicaid information.

Retro-Processing Contractor and Processing of the Request

The Retroactive Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retroactive Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the organization including the reason that the adjustment was not processed. The Retroactive Processing Contractor will return the request without action, if the documentation is not complete.

The Retroactive Processing Contractor will return the request without action if the dates of Medicaid status are older than 36 months prior to the receipt of the request by the RO.

The Retroactive Processing Contractor will return the request without action if the beneficiary was not a member of the plan for the discrepancy period. If the Medicaid status for the period requested in the adjustment reflects the current Medicaid periods, return it to the organization without action. If not, the Retroactive Processing Contractor will validate the requested change and enter the revised Medicaid status into MARx.