pennsylvania
DEPARTMENT OF HUMAN SERVICES

DATE: March 16, 2015

OPERATIONS MEMORANDUM #15-03-01

SUBJECT: Health Care Program – Overpayment Referrals

TO: Executive Directors

FROM: Inez Titus
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PURPOSE

1. To update procedures for the referral of health care benefits (including Buy-In) overpayments.

2. To establish procedures for making changes to health care benefits overpayments referred to the Office of Inspector General (OIG) for collection as well as procedures for appeal requests.

3. To implement these procedures for health care benefits overpayments upon receipt of this memorandum.

NOTE: There is no change to the process for Long Term Care (LTC) or Home and Community Based Services (HCBS) overpayments.

NOTE: Health care benefits refer to both Medical Assistance (MA) and Private Coverage Option benefits unless otherwise noted.

BACKGROUND

The Supplemental Handbook (SH) 910 states that the County Assistance Office (CAO) is responsible for determining overpayments for recipients of health care benefits, and referring overpayments to OIG for collection. Only MA overpayments caused by client error/fraud are collected by the OIG.

- PS 120404 established procedures for determining health care benefits overpayments (excluding Buy-In) and the manual referral of health care benefits overpayments (excluding Buy-In) to the OIG for collection.

- OPS 130401 established procedures for referring health care benefits overpayments (excluding Buy-In) through the Automated Restitution Referral

and Computation (ARRC) to the OIG for collection and established procedures for determining Buy-In overpayments and manually referring these overpayments to the OIG for collection.

OPS 120404 and OPS 130401 will become obsolete upon publication of this OPS Memo.

Due to limitations with the ARRC system, health care benefits overpayments cannot be collected by the OIG without additional information regarding claims paid on behalf of recipients for medical services, as well as managed care fees. Calculation of the claim amount continues to be required outside of ARRC, and Buy-In continues to require a paper OIG 189.

DISCUSSION

The CAO must determine if an overpayment occurred and if a claim results. All health care benefits overpayments excluding Buy-In are referred through the ARRC system to the OIG for collection. The amount of the claim is determined through an inquiry to the Data Warehouse. The **PA 189** (Attachment 6) is used to prepare the data entry for ARRC referrals. The ARRC system has been updated to include the ability to request changes to health care benefits referrals previously made through the ARRC system and to request and record the disposition of health care benefits overpayment appeals.

Buy-In overpayments are referred through a completely manual process to the OIG for collection using the **OIG 189** (Attachment 2). The amount of the claim is determined using Exchange 7 data. Since Buy-In uses a completely manual process for referral of Overpayments to OIG for collection, changes to and rescissions of those referrals are made manually. Requests for appeal of decisions on overpayment collections by OIG are made manually using the procedures in SH 910.55.

The CAO will take the following steps to determine if an overpayment occurred:

1. Obtain necessary verification related to the possible overpayment.

2. Determine when the overpayment began. If the individual did not report a change timely, the overpayment begins the first month in which the individual(s) no longer qualify for health care benefits and/or Buy-In. Discontinue health care and/or Buy-In for the individual(s) after sending an advance notice and allowing the required 15 days for the notice to expire.

3. Determine whether each recipient was eligible for any other category of health care benefits except TA/TJ 65/67 (including MAWD and Select Plan)

during the period of possible ineligibility (Select Plan will end June 30, 2015). Use the manual eligibility computation worksheets in Attachment 1. For resource ineligibility, give the individual the opportunity to spend down excess resources on a medical service.

NOTE: For resource overpayments, the amount of the claim is the total net resource or the total amount of assistance received during the overpayment period, whichever is less.

4. If the recipient qualifies for another health care category not TA/TJ 65/67, no overpayment is sent to OIG. To meet auditor requirements, continue to narrate and enter partial ineligibility overpayments in ARRC using the PA 189, but no documentation is sent to OIG.

NOTE: If a Cash Assistance recipient received cash assistance while totally ineligible, complete a manual determination of health care eligibility before completing a health care benefits overpayment. There is no change to the process for completing a Cash Assistance overpayment.

NOTE: If a health care benefits recipient received buy-in as part of a health care benefits category for which there is an overpayment, complete a separate manual overpayment for the amount of Medicare premiums paid by the Commonwealth as well as the Non-money Payment (NMP) MA.

The CAO will take the following steps for the individual(s) totally ineligible for health care benefits (except Buy-In):

1. The Caseworker narrates the health care benefits overpayment including:

   - Name of the individual who caused the overpayment.
   - Reason for the overpayment.
   - Time period of the overpayment.
   - Any other relevant information related to the overpayment.

2. The caseworker completes the PA 189 (Attachment 6) and forwards the form to the office designee to obtain medical claim information. Multiple health care budgets may be included on one PA 189.

   NOTE: Each CAO will select an Income Maintenance Casework Supervisor/Manager and an alternate to be responsible for researching health care benefits claim information in the Data Warehouse. The CAO must develop a process for caseworkers to follow when requesting claim information from the office designee.

3. The office designee requests all managed care, Private Coverage Option, and fee-for-service claim information for the period of the health care benefits overpayment for each recipient determined totally ineligible for health care benefits using the Instructions for Data Warehouse Inquiry (Attachment 3).

4. CAOs are only required to record what appears on the query as of the point in time the query is completed.

5. The office designee enters the claim information on the OIG 764 C1 (Attachment 4) for each ineligible individual on a separate tab in the worksheet and also completes the summary sheet using the Instructions for Completing the OIG 764 C1 (Attachment 5). The PA189 and OIG 764 C1 (summary and ineligible pages) are returned to the caseworker. The OIG 764 C1 must be completed in Excel and cannot contain any handwritten information. Any months during a claim period where there are no benefits overpaid should show a zero claim amount. A separate PA 189 is not required if there is a break in the claim period of the overpayment, or for different health care budgets within the same record number.

6. The caseworker completes the ARCAPA and ARCAEM (if applicable) fields on the PA 189 (Attachment 6) and gives the form to clerical staff for data entry to establish a claim in ARRC. Use the updated "reason" codes found on page 2 of the OIG 189 dated November 2012 or later.

7. Clerical staff completes data entry of ARCAPA and ARCAEM in ARRC. Clerical returns the PA 189 to the caseworker for ARCAFQ completion.

8. For cases with claim amounts, the caseworker answers question #1 on the ARCAFQ screen with "Y", answers the remaining questions appropriately, and proceeds to step 8 below. For cases with no claim amounts, the caseworker answers question #1 with "N", and proceeds to step 9 below.

9. For cases with claim amounts, the caseworker completes the ARCAFA section of the PA 189. In order for the claim to pass to the Office of Inspector General Avoidance and Recovery System (OARS), this section **must** contain:

   - Category
   - Type (check "Medical")
   - Health Care Claim Period
   - Ineligible Line Numbers (leave blank if all recipients are ineligible)
   - Health Care Claim Amount

The caseworker returns the PA 189 to clerical for data entry of the ARCAFA section.

10. The caseworker, or clerical staff scans and attaches all overpayment documentation, including the OIG 764 C1, health care benefits eligibility computation sheets, data warehouse documentation, and verification, to the case record as one document. Use identifier “PA 189” for the overpayment packet.

11. For cases with claim amounts, the CAO mails the PA 189, supporting documentation (including data warehouse documentation) and all completed pages of the OIG 764 C1, including the summary and individual ineligible pages to:

    Office of Inspector General
    Bureau of Fraud Prevention and Prosecution
    Attn: Operations Support Division
    P.O. Box 8016
    Harrisburg, PA 17101.

The CAO will take the following steps for the individual(s) ineligible for Buy-In:

1. The caseworker narrates the Buy-In overpayment including:

   - Name of the individual who caused the overpayment.
   - Reason for the overpayment.
   - Time period of the overpayment.
   - Any other relevant information related to the overpayment.

2. The caseworker completes the paper OIG 189 Overpayment Referral form (Attachment 2) and obtains the Buy-In amounts overpaid using Data Exchange 7.

3. The caseworker enters the Buy-In amounts overpaid on the OIG 765 C1 (Attachment 10) for each ineligible individual using the Instructions for Completing the OIG 765 C1 (Attachment 9). The OIG 765 C1 must be completed in Excel and cannot contain any handwritten information.

4. The caseworker completes the ARCAPA and ARCAEM (if applicable) fields on the PA 189 and gives the form to clerical staff for data entry.

5. Clerical staff completes data entry of ARCAPA and ARCAEM in ARRC.

6. The caseworker answers question #1 on the ARCAFQ screen with “M” indicating manual referral (paper OIG 189 completed).

7. The caseworker or clerical staff scans and attaches all overpayment documentation, including OIG 765 C1, screen print of Data Exchange 7, MA eligibility computation sheets, and verification, to the case record as one document. Use identifier “OIG 189” for the overpayment packet.

8. The CAO mails the OIG 189, supporting documentation (including Data Exchange documentation) and all completed pages of the OIG 765 C1, including the summary and individual ineligible pages, to:

   Office of Inspector General
   Bureau of Fraud Prevention and Prosecution
   Attn: Operations Support Division
   P.O. Box 8016
   Harrisburg, PA 17101

Completing the Overpayment Referral form (OIG 189)**:**

Completion of the OIG 189 is required to refer Buy-In overpayments to the OIG.

Follow instructions for completing OIG 189 referral in SH 910, Appendix A.

NOTE: Indicate at the top of the OIG 189 if the household’s language indicator is 02 (Spanish) to ensure the proper notice is sent.

NOTE: Indicate at the top of the OIG 189 if the overpayment is for Buy-In.

NOTE: Individual Number for Claim Name: Leave this field blank.

How are manual overpayments rescinded?

To rescind a manual overpayment, the CAO alerts OIG Headquarters by sending an email to RA-cao189@pa.gov and indicates that the overpayment needs to be rescinded. ARRC does not accept or pass rescind codes to OARS in the case of manual overpayments which used OIG 189, including Buy-In overpayments.

How are health care overpayments completed in ARRC rescinded?

To rescind a health care benefits overpayment referral where the claim (including claim amount) was transmitted through ARRC to OIG's OARS system, the CAO completes the following steps:

1. The caseworker completes the PA 1001 section ARCHMC with disposition code 22 and gives form to supervisor for approval.
2. The PA 1001 is given to clerical to complete data entry of ARCHMC in ARRC.

3. If clerical receives an error message that an update is not allowed, the CAO should contact OIG to release the claim in OARS, and the rescission can be completed the next business day.

How are manually referred health care overpayments changed or corrected?

To change or correct a health care manual overpayment referral where the claim was referred to the OIG via a paper OIG 189, the CAO must complete the following:

1. To change the data of an overpayment previously referred, complete a corrected OIG 189 and write in Red across the top "Corrected 189." Indicate on the original referral what information has changed. The "Corrected OIG 189" does not have to be signed by OIG.

2. Complete a new OIG 764 C1 for health care benefits not TA/TJ 65/67 marked "CORRECTED" in red at the top and forward it to the OIG. The original query should be used. The new computation should be scanned into imaging (including the query). For Buy-In, use 765 C1.

3. Attach a copy of the original OIG 189 and the corrected OIG 189 to any other documentation including the 764 C1 with query and computation sheets. Send to OIG.

NOTE: Either the amount or claim periods can be changed, or both can be changed. The amount can only be reduced and the dates made shorter, similar to Cash and SNAP. Do not request a new query from the Data Warehouse; use the original query.

How are health care benefits overpayments completed in ARRC changed or corrected?

Note: Using ARRC has been updated to include the procedures for making changes and corrections to health care benefits overpayment screens.

To change or correct a health care benefits overpayment referral where the claim (including claim amount) was transmitted through ARRC to OARS, the CAO must complete the following steps:

1. The caseworker completes a new OIG 764C1 marked “CORRECTED” in red at the top and forward it to OIG. The new computation should be scanned into imaging (including the query).

2. The caseworker completes the PA 1001 (Attachment 11) section ARCHMC with disposition code 03, updated claim periods and amount, and gives the form to the supervisor for approval.

NOTE: Either the amount or claim periods can be changed, or both can be changed. The amount can only be reduced and the dates made shorter, similar to Cash and SNAP. Do not request a new query from the Data Warehouse, use the original query.

3. The caseworker gives the PA 1001 (Attachment 11) to clerical to complete data entry of ARCHMC in ARRC.

4. If clerical receives an error message that an update is not allowed, the CAO should contact OIG to release the claim in OARS, and the change/correction can be completed the next business day.

How will appeals be processed for health care and/or Buy-In overpayments?

Process appeals on manually referred claims (Paper OIG 189s) as outlined in SH 870.22. The appeal process for manually referred health care benefits overpayment is still manual.

Process appeals on ARRC referred claims by completing the PA 1001 (Attachment 11) section ARCHAP Appeal Request with the date of request, and give the form to the supervisor for approval. The PA 1001 is given to clerical to complete data entry of ARCHAP in ARRC.

When the appeal is adjudicated, complete a PA 1001 section ARCHAP Appeal Disposition with the appropriate disposition code and the date of disposition, and give to the supervisor for approval. The PA 1001 is given to clerical to complete data entry of ARCHAP in ARRC.

Note: Using ARRC has been updated to include the procedures for recording appeals and appeal disposition to health care benefits overpayment screens.

NEXT STEPS

1. Share this information with appropriate staff.

2. OPS 120404 and 130401 are obsolete.

3. Keep this memorandum until this information is incorporated into the Supplemental Handbook.

4. Direct any questions to your Area Manager.

Attachments:

Attachment 1	MA Computation Worksheets- PDF format
Attachment 2	OIG 189
Attachment 3	Instructions for Data Warehouse Inquiry
Attachment 4	OIG 764 C1
Attachment 5	Instructions for Completing the OIG 764 C1
Attachment 6	PA 189
Attachment 7	MA Overpayment Process Q&As
Attachment 8	MA Overpayment OIG Tip Sheet
Attachment 9	Instructions for Completing the OIG 765 C1
Attachment 10	OIG 765 C1
Attachment 11	PA 1001