

Department of Public Health  
and Human Services

Section:  
CASE MANAGEMENT

FAMILY MEDICAID

Subject:  
Overissuance

**Supersedes:** FMA 1504-1 (07/01/05), Bulletin FMA-39 (10/12/05)

► **References:** 42 U.S.C. 1396b(u) and 1396p(a); 42 CFR 431.210, .211, .213 and .214; 42 CFR 433.36(g)(1); 53-2-108, MCA; ARM 37.82.101, .207; ARM 37.5.505

► GENERAL RULE—The Department will establish claims for the overissuance of Medicaid benefits for all eligibility errors that are not DPHHS-caused errors, such as a recipient's inadvertent error or intentional act or omission. A Medicaid overissuance claim will not be established when the error was caused by the Department (i.e., administrative error).

► Medicaid overissuance claims will not be created or pursued by DPHHS if the Medicaid issuance was a result of an SSI payment being made in error to the recipient.

► Only Medicaid overissuance situations that occurred on or after January 1, 2003 can be collected. Overissuance situations that occurred prior to January 1, 2003 cannot be collected and no claim can be established.

**EXCEPTION:** Overissuance claims will be established on cases that received continued assistance during the fair hearings process when the agency is upheld. These claims will be established regardless of whether the continuation of assistance was received before or after January 2003.

**NOTE:** In cases involving nursing home liability, patient liability can only be changed prospectively, and then only when at least adequate notice can be given. A Medicaid overissuance will be calculated according to the policy in this section for incorrect patient liability for months prior to the month in which adequate notice is given, provided the incorrect liability was not a result of administrative error.

## OVERPAYMENT LOGS

Any potential Medicaid overissuance is to be recorded on the electronic 'OPA Monthly TANF and Medicaid Overpayment Log'. Cases considered to have a potential overissuance would include those in which an error has been identified but the eligibility case manager has not yet had time to rework the case to determine if there is an overissuance.

The log specifically addresses date of discovery of potential overissuance, the date the overissuance was processed and whether the error was client or agency caused. If the error did not result in an overissuance, 'N/A' should be entered in the 'date processed' field. Any overissuance that has been determined to be recipient-caused and that occurred on or after January 1, 2003 must be established. Case notes must also be entered explaining what caused the overissuance (i.e., income or resources) and when it was discovered.

At the end of the month, the completed log will be submitted to the supervisor or designee, who will monitor overissuance and keep a central file for each respective work unit. The log is not sent to Central Office.

**► DETERMINING  
OVERISSUANCE  
AMOUNT**

Regardless of whether the recipient(s) were ineligible for Medicaid due to excess income or resources, the overissuance claim amount equals the smaller of the total amount of benefits paid to Medicaid providers on behalf of the ineligible recipient(s) or the amount by which income or resources exceeded program standards in the benefit month.

If a recipient was correctly determined to be eligible under medically needy but the incurment amount was understated, the overissuance is calculated differently, depending on whether the recipient chose cash option or medical expense option:

- Cash option: The overissuance claim is the smaller of the difference between the original, incorrect incurment and the correct incurment obligation, or the difference between Medicaid expenditures and the amount of benefits paid to Medicaid providers on behalf of the recipient(s).
- Medical expense option: The overissuance claim is the smaller of the difference between the original, incorrect incurment and the correct incurment obligation, or the total amount of benefits paid to Medicaid providers on behalf of the recipient(s) during the benefit month in error.

Example 1: George is medically needy eligible; George chooses the medical expense option. His incurment is calculated to be \$175 per month. It is later discovered that George did not report all of his income for two months. When the additional income is included, George's incurment is recalculated to be \$200 per month. In the first overissuance month, Medicaid payments to providers totaled \$190. For this month, the

overissuance claim amount is \$25 (\$200 correct incurment - 175 incorrect incurment = \$25, which is less than the \$190 Medicaid paid). For the second month, Medicaid payments to providers totaled \$15. For the second month, the overissuance claim amount is \$15 (\$15 in Medicaid payments is less than \$200 correct incurment - 175 incorrect incurment = \$25).

Example 2: Madge is medically needy eligible; Madge chooses the cash option. Her incurment is calculated to be \$175 per month. It is later discovered that Mabel did not report all of her income for two months. When the additional income is included, Madge's incurment is recalculated to be \$200 per month. In the first overissuance month, Medicaid payments to providers totaled \$190. For this month, the overissuance claim amount is \$15 (\$190 in Medicaid payments - \$175 actual cash option payment = \$15, which is less than \$200 correct incurment - \$175 incorrect incurment). For the second month, Medicaid payments to providers totaled \$300. For the second month, the overissuance claim amount is \$25 (\$200 correct incurment - 175 incorrect incurment = \$25 is less than \$300 in Medicaid payments - \$175 actual cash option payment = \$125).

If George or Madge had correctly reported income, but the eligibility case manager miscalculated the incurment amounts, there would be no overissuance established.

## PROCEDURE

## ACTION

### Eligibility Case Manager

1. Upon discovery, determine the total overissuance period (cannot be prior to January 1, 2003 unless caused by receipt of continued assistance) and log the overissuance on the 'OPA Monthly TANF and Medicaid Overpayment Log'.
 

**NOTE:** The overissuance period must include all months which contain an overissuance, beginning with the month the change would have been effective had it been known and acted upon timely.
2. Enter detailed case notes explaining the overissuance cause, period, etc. The case note should be titled similar to "Medicaid Overissuance 1/03 – 5/03". This will allow the Claims and Recovery Unit to easily identify the correct case note for use when the claim is being established.

Section: CASE MANAGEMENT

Subject: Overissuance

3. Contact Rolene Benson to request total Medicaid claims paid, broken down to monthly totals, for the entire overissuance period.
- Claims & Recovery** 4. Send e-mail response to OPA listing total Medicaid claims paid, broken down to monthly totals, as requested.
- Eligibility Case Manager** 5. Send appropriate system notice informing the household of a potential overissuance.
6. At least 13, but no more than 14 months following the last overissuance month, establish the claim against the responsible household members at the time of the overissuance. A claim is established by completing all sections on the electronic 'Medicaid Recipient Overpayment Referral' except the 'O/P AMOUNT' section, and e-mailing the referral to Rolene Benson in the Claims and Recovery Unit.
- NOTE:** If more than one household member has an overissuance, enter each member's SSN, and their overissuance period on the referral.
- If the overissuance is due to an understated liability (medically needy case), the eligibility case manager will also complete the green 'O/P AMOUNT' section before e-mailing to Claims and Recovery.
- NOTE:** It takes a minimum of 13 months to determine the Medicaid overpayment amount. This is because Medicaid providers have 365 days (one year) from the date of service to bill Medicaid.
- Claims & Recovery** 7. Determine the total overissuance amount by obtaining a printout of all Medicaid expenditures for the individual/family for the identified overissuance period.
8. Complete green section (O/P AMOUNT) on 'Medicaid Recipient Overpayment Referral' and e-mail back to eligibility case manager.
- Eligibility Case Manager** 9. Send appropriate system overissuance notice informing the individual/family of the overissuance amount and the need to contact the Claims and Recovery Unit to establish payment arrangements.
- Claims & Recovery** 10. Negotiate repayment agreement.

**NOTE:** OPA staff must not attempt to negotiate repayment agreements. The Claims and Recovery Unit will handle all negotiations regarding Medicaid overissuances.

**► OVERISSUANCE CONTACTS**

Eligibility case managers should call Rolene Benson in the Program Integrity Claims and Recovery Unit, (406) 444-9361 with any questions or issues with overissuance situations. If an overissuance has been sent to Program Integrity and it needs to be reversed, cancelled or changed, county directors or supervisors should e-mail Rolene Benson with the information, for audit purposes. Supervisory approval is required for all reversals, cancellations and changes to overissuance claims.

Recipients or former recipients with questions regarding repayments, Medicaid overissuance collection (dunning) letters or overissuance situations should call 444-2978.

Recipients or former recipients with questions regarding Tax Offset Payments for overissuance should call 1-888-241-8657 or 444-4176.

Medicaid fraud reports should be referred to 1-800-201-6308.

Program Integrity Claims and Recovery Unit requests that individual staff members' direct phone numbers not be provided to recipients and former recipients, except as listed above.

**► SETTLEMENTS**

When a Medicaid recipient receives reimbursement for medical expenses in the form of a settlement (i.e., automobile insurance or workers' comp settlement), and Medicaid has paid for the medical care for which they are being reimbursed, an overissuance must be established.

The Third Party Liability (TPL) Unit always handles this type of overissuance.

OPA staff must notify the TPL Unit (via phone or e-mail) if such an overissuance is discovered. Typically, TPL will discover the settlement and establish the overissuance claim. In this instance, TPL will enter system case notes, send appropriate system notices and complete the electronic overissuance referral.

**► \*\*01/01/08 PROVIDER OVERPAYMENTS**

Overpayments of Medicaid dollars to providers based on billing errors or provider fraud are pursued by SURS (Surveillance Utilization and Review Section) of the Quality Assurance Division of DPHHS, and should be referred to that division for investigation.

**UNDERISSUANCE**

Occasionally, information is discovered on a Medicaid case that results in an earlier eligibility date or a lower cash option obligation. When this occurs, methods of adjustment are as follows:

Change results in an earlier eligibility date: Update case for the affected month(s). Revert to open, if necessary. If case was open, but for a later eligibility date (i.e., a Medically Needy medical expense option), correct case information and re-authorize. Issue HCS-455 forms to providers as necessary.

Change results in cash option overpayment by client: If cash option was paid by recipient, a refund of cash option payments can be made for up to the previous 12 months. Refund is accomplished by sending a detailed explanation of the case circumstances that led to the overpayment of cash option to the ABD policy specialist, who will review the case and authorize the refund payment by fiscal bureau. See MA 702-2 for Cash Option Refund procedure.

nc/KQ

o O o