

Medicaid Status Changes Submission Process and SOPs

Overview:

Organizations must submit requests to the Retroactive Processing Contractor (RPC) 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 plan 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 or plan must retain the original supporting documentation for the requested changes as they may be required to produce it during a CMS audit or RPC Probe Study at a later date.

Submitting Medicaid Status Changes (or Adds)

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 35 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 only 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:			
Validate Medicaid			Medicaid			
Contract Number	Plan Type	HIC	Last_Name	First_Name	Start_Date	End_Date
					mm/dd/yyyy	mm/dd/yyyy

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 plan 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 35 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 only 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			
Validate MED REM					Medicaid Removal	
Contract Number	Plan Type	HIC	Last_Name	First_Name	Start_Date	End_Date
					mm/dd/yyyy	mm/dd/yyyy

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

Plans must submit retroactive payment adjustment requests electronically using the formatted spreadsheet provided in the RPC toolkit. Plans can request a copy of this spreadsheet directly from the Retroactive Processing Contractor or it can be downloaded from its web site at www.reedassociates.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

Contract Number:	Format as a text field. Field is limited to 5 characters
Plan Type:	Format as a text field.
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

Start_Date:	Format as a date field and enter the start date as 03/01/1998
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
- Microsoft Excel 2007

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:

Reed & Associates, CPAs
Attention: RPC
14301 FNB Parkways, Suite 211
Omaha, NE 68164
Phone: 402-315-3660

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 dual eligible and pay their Part B premium.

General Information about Medicaid Payments:

Please refer to the latest guidance and policies provided by CMS on Medicaid Status for Part C and Part D Risk Adjustments.

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 plans 6 months in which to report discrepancies. Any requests with an effective date of greater than 6 months requires additional documentation. Refer to HPMS memo, July 15, 2005 on Timeliness of Retroactive Adjustment Submissions for requests over 6 months old.

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

To follow up on specific previously submitted adjustments, please contact Client Services at 402-315-3660.

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 Retro-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.

Documentation Required to Retroactively Change the Medicaid Status of a Beneficiary

*****these items should only be sent when a request is older than 6 months or when requested by the RPC.***

- 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 35 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 in GHP, 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.

Qualified Medicare Beneficiary (QMB)	<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 	YES
Specified Low-Income Medicare Beneficiary (SLMB)	<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 	YES
Qualifying Individual-1 (QI-1)	<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 	Beginning in 2005