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## AGING PROGRAM DIRECTIVE

**SUBJECT:** PDA WAIVER PAID CLAIMS RECONCILIATION

**TO:** COUNTY COMMISSIONERS
CHAIRPERSONS, NON-PROFIT AAA
  GOVERNING BOARD

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DPW OFFICE OF PROGRAM
  DEVELOPMENT AND SUPPORT
COUNTY COMMISSIONERS
  ASSOCIATION OF PENNSYLVANIA
COMPTROLLER

**FROM:**

RICHARD BROWDIE
SECRETARY
DEPARTMENT OF AGING

**PURPOSE:** The purpose of this Aging Program Directive is to set forth policy and procedures regarding the reconciliation of paid claims for PDA Waiver Services and the actions to take, should discrepancies be detected.

**BACKGROUND:** The Health Care Financing Administration (HCFA) requires that a monitoring system be emplaced to ensure appropriate billings and payments for Medicaid services authorized under the Pennsylvania Department of Aging (PDA) 1915 © Waiver. This means that a percentage of all claims paid by the Department of Public Welfare (DPW) for Waiver services must be reconciled against the service order authorizing the service. This is to ensure that the total cost for the service as billed by the provider and reimbursed by DPW was correct and that there was no overpayment.

**CONTENT:** This Aging Program Directive contains the requirements and procedures for Area Agencies on Aging to follow to meet the HCFA monitoring requirements, and the procedures to follow to report compliance and any discrepancies noted.

## Waiver Paid Claims Reconciliation

### Purpose

1) The Health Care Financing Administration (HCFA) requires that a monitoring system be emplaced to ensure appropriate billings and payments for Medicaid services authorized under the Pennsylvania Department of Aging (PDA) 1915 © Waiver, hereafter referred to as the PDA Waiver. This means that a percentage of all claims paid by the Department of Public Welfare (DPW) for Waiver services must be reconciled against the service order authorizing the service for the specific consumer by the specific provider. This is to ensure that the units of service, cost per unit of service, and total cost for the service as billed by the provider and reimbursed by DPW are correct and that there was no overpayment, caused by a variance either in the number of units claimed or the cost per unit.

### Discussion

2) This monitoring function can best be performed at the Area Agencies on Aging (AAAs), where the services are authorized and service records are maintained. PDA has entered into a contract with Synergy Software to develop a computer program which will automatically and electronically perform a 100% reconciliation of all paid claims to service orders, and will generate an exception report showing where the provider has billed for less than or more than, the amount of services specified in the service order.

3) Until this program becomes available, AAAs must perform this check themselves, either through a locally developed computer program to interface paid claims records with service orders stored in an electronic database, or through a manual check of paid claims with service orders, stored either electronically or on paper.

### Selecting Records for Reconciliation

4) To perform this function, AAAs must have the paid claims records for Waiver services. PDA has developed a system for creating a computer file that can be easily imported into Microsoft Excel, Microsoft Access, or other database systems for use at the AAAs.

5) This data file will contain all the payment information necessary for the AAAs to crosscheck service orders with paid claims to ensure appropriate payments. The format and download instructions for this file are provided at Attachment #1. The file will be provided automatically on a monthly basis to all AAAs with an active PDA Waiver caseload. This file will contain a listing of all PDA Waiver paid claims adjudicated during the previous month. The file will normally be generated on the 10th day of the month and will be positioned in the AAA's folder on the PDA AS/400.

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6) The file will be named "CWyymmnn", where "yy" is the fiscal year, "mm" is the reporting period and "nn" is the AAA number, i.e. CW000451. Once the file is positioned in the AAA folder, a message will be sent to the AAA by fax informing the AAA that the file was created. The AAA will then have 10 days to copy the file onto their local file server/PC. After the AAA copies the file into the local files, the AAA should remove the file from the AAA folder on the PDA AS/400. AAAs can copy and delete the file in one action by using the "Cut and Paste" functionality in their computer. This will be a sign to PDA that the AAA has initiated the monitoring actions.

7) If the AAA does not copy and remove the file within 10 days, a message is generated to the PDA program analyst regarding this. The program analyst will then notify the AAA, informing it that the file is present and will be deleted automatically if the AAA does not perform the necessary actions. This is repeated for five (5) days, after which time the file will be deleted by PDA.

8) Once the AAA has copied the file to its local files, the paid claims' reconciliation can begin. This reconciliation can be done several ways, so long as the end result is a comparison of the paid claim to the related service order. The AAA must confirm that units of service and cost per unit for the paid claim do not exceed those authorized by the service order.

9) To meet HCFA requirements, it is necessary that each AAA reconcile at least 10% of its monthly waiver paid claims to the service orders. This should be a random sample among all paid claims to ensure an equal positive probability of selecting any claim. Since waiver paid claims are entered into the paid claims file in no particular order, following a consistent systematic extraction from the file will ensure a random sample of paid claims for reconciliation.

10) A method of systematic selection to ensure a random sample is as follows: divide the number of records by 10. Randomly select a starting number between 1 and the result from the previous operation. For example, if the AAA has 150 claims, randomly select a number between 1 and 15. This will be the first paid claim to reconcile in the file, then every tenth claim in order in the file, and the last claim in the file. As an example, in a file with 37 claims, you would select a number between 1 and 4. Suppose the number selected was 3. You would then reconcile claims 3, 13, 23, 33, and 37. This results in 5 claims, which is 13.5%, greater than 10%, thereby exceeding the HCFA requirement and ensuring an adequate sample size for reconciliation.

11) To reconcile a Waiver paid claim against the service order, the AAA must record within the consumer's records the Client Information System (CIS) number by which DPW identifies and tracks MA recipients. This CIS number, which is obtained from the County Assistance Office when the consumer is enrolled in

MA, can be accessed from the CQMENU on the DPW computer system, or can be gotten from the consumer's MA enrollment card.

## Reconciliation Procedures

12) The procedures described here are for manual reconciliation of waiver paid claims, however the mechanics can be applied for use in automated systems as well. Actions to be taken as a result of these checks are **Post Reconciliation Actions**.

   a) Import the waiver paid claims file into an Excel worksheet using the procedures on Appendix 1. Select the specific records to be reconciled using a systematic procedure such as in paragraph 10 above.

   b) From the selected record, use the Recipient CIS Number to locate the waiver recipient's case file, either paper copy or electronic storage. Match the recipient's name and county of residence to verify this is the correct recipient.

   c) From the paid claim record, use the Date of Service to determine the month in which the service was provided. This will identify which monthly care plan to check. For example, if the Date of Service were 5/12/1999, the care plan to check would be for May 1999.

   d) Once the correct care plan is identified, check to ensure that the provider, by MA Provider ID Number, listed on the paid claim is listed on the care plan and that a service order has been generated to the provider for this care plan month.

   e) If there is a service order to the provider for this care plan month, check that the ordered service, by procedure code, listed on the paid claim is listed on the service order.

   f) Having determined that the service by procedure code was ordered from the provider for the recipient for that care plan month, check the Credit Code and Credit Description.

      1) If the Credit Code is a "1" and the Credit Description is "**Original**", this is the initial invoice for this paid claim.

      2) If the Credit Code is "2" and the Credit Description is "**Cancellation**", this is a change to an original claim filed by the provider and is used to cancel out a prior

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paid claim. The provider, for many reasons, adjusts original claims. Among them are wrong procedure code, incorrect units, or price.

3) The provider may cancel the claim and make no adjustment to it. Reasons for this may be the service was not performed, or billed to the wrong recipient.

4) If the claim is to be amended, it should be immediately followed by another claim for the recipient. This claim has a Credit Code "3", Credit Description "**Adjustment**", which records the adjusted claim with the corrections.

g) If your selected claim has a Credit Code of "1", check to ensure that the "Quantity Paid For" is less than or equal to the quantity ordered on the service order. The "Amount Paid" must be less than or equal to the "Amount Billed" and should be less than or equal to the total cost recorded on the service order and care plan.

h) If your selected claim has a Credit Code of "2", check to see if the following claim has a Credit Code of "3" and is the adjustment to the cancellation. If this is the case, perform the same checks as for a Credit Code of "1", to include all checks for recipient and provider using the adjusted claim with the Credit Code of "3" for the reconciliation.

i) Check to ensure that the claim with the Credit Code of "2" completely and correctly cancels the original prior claim with Credit Code of "1".

j) If your selected claim has a Credit Code of "2" and there is no following claim with a Credit Code of "3", this was a true cancellation of a previously submitted and paid claim. There are no further checks to make.

k) If your selected claim has a Credit Code of "3", this is an adjustment to a prior claim. Ensure the previous claim in the paid claims file has a Credit Code of "2" and is the cancellation of the claim this record is adjusting. Perform the same checks as for a Credit Code of "1", to include all checks for recipient and provider using the adjusted claim with the Credit Code of "3" for the reconciliation.

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## Post Reconciliation Actions

13) If any of the following were noted while reconciling a paid claim record to the service order and/or care plan, immediately contact the provider to determine if the problem is with the AAA records or at the provider.

   a) The Provider specified in the paid claim record is not listed as a provider for the recipient.

   b) The Recipient listed in the paid claim record is not enrolled in the PDA Waiver.

   c) The Procedure Code specified in the paid claim record is not authorized for the provider.

   d) The Procedure Code specified in the paid claim record was not ordered for the recipient.

   e) The Quantity Paid For in the paid claim record is not equal to the quantity ordered in the service order.

   f) The Amount Paid is greater than the amount authorized in the service order/care plan.

14) If the problem is at the AAA and the provider has performed all services to the satisfaction of the recipient and the care manager, the AAA should update its records and no further actions are required.

15) If the provider has failed to provide the quantity of services ordered, the AAA needs to determine if the reasons offered by the provider are acceptable. If not, corrective action must be taken to ensure that the provider is able to deliver the services as ordered.

16) If the provider has billed for a quantity of services in excess of that authorized by the service order and there are no additional records or approvals for these excess services, the AAA must notify the provider to submit an adjustment to the paid claim, specifying the correct quantity so that there is no overpayment for services which were not ordered.

17) The AAA must also consider if there is cause to believe there was intent to defraud the government, or if this was an honest mistake. If there are indications of intent to defraud, the AAA must notify DPW, the Bureau of Program Integrity, so that an official investigation can be undertaken. In addition, the AAA should consider whether this provider should be decertified as a PDA Waiver provider.

18) In those instances where the provider has to submit an adjustment to the paid claim, the AAA must follow this adjustment to ensure it was submitted and properly processed.

## Reports

19) As with any monitoring program, certain reports are required to record the performance of the monitoring actions. The following are the required reports and the triggering actions for their submission.

    a) The AAA will establish a monthly file listing which paid claims' records were reconciled, the reconciliation findings, and what corrective actions, if any, were taken. This report may be stored either electronically, or on paper and will be retained for one (1) year after the end of the fiscal year to which it applies. This report will utilize the format provided at Attachment #2.

    b) Each AAA will establish a file to record an ongoing summary of the monthly reconciliation. This file will be named WRECnn, where nn is the PSA number. Each month, after completing the reconciliation, AAAs will position the file in their folder on the PDA AS/400. Upon receipt, PDA/MIS will remove the file from the folder and position it in a separate folder for use by PDA personnel. This file will use the format at Attachment #3.

    c) AAAs will submit a report to DPW/BPI whenever local attempts to reconcile variances in paid claims which show overpayment to the provider are not resolved either by the provider submitting an adjustment, or the AAA correcting appropriate service orders. This report will use the format provided at Attachment #4.

    d) PDA will provide to DPW/LTC quarterly, a report of the findings from the AAAs and the actions taken to correct these problems. This report will use the format provided at Attachment #5.

## Waiver Paid Claims File

The Waiver Paid Claims' Record is an ANSI text comma delimited file. It can be readily imported into an Excel worksheet using the following procedures.

1) Using a personal computer that is connected and active with the PDA AS/400, open an Excel file to a blank worksheet.

2) To access the paid claims' file in the AAA's folder of the PDA AS/400, from the open Excel file blank worksheet, import the paid claims' file. Do this by selecting "**Open**" from the file pull down menu or by selecting the "**Open File**" icon on the tool bar. Select the drive on which you have mapped your AAA folder on the PDA AS/400. Set the File of Type to either "**All Files**" or "**Text Files**". This will show the file name for your paid claims' file.

3) Either double click on the file name, or click on the file name, and then click on "**Open**". This will open the "**Text Import Wizard-Step 1 of 3**" window. Ensure that file type "**Delimited**" is highlighted. If it is not, click on the word "**Delimited**" or in the circle to the left of the work "**Delimited**". Once this is done, click "**Next**".

4) This opens the window, "**Text Import Wizard-Step 2 of 3**". Ensure the word "**Comma**" is highlighted. If it is not, click on the word "**Comma**", or click in the box to the left of the word "**Comma**". Once this is done, click on the word "**Next**".

5) This opens the window, "**Text Import Wizard-Step 3 of 3**". There are no actions necessary here, so just click on the word "**Finish**". This will complete the importation of the paid claims' file into the Excel worksheet. For readability, it will be necessary to expand the columns to full width so you can read the column headings.

Data contained with the record are as follows:

**AAA Code** – The Planning Service Area (PSA) number of the PSA in which the Waiver recipient is care managed.

**AAA Name** – The name of the PSA.

**County Code** – The DPW assigned code for the county in which the waiver recipient resides.

**County Name** – The name of the county in which the waiver recipient resides.

**Recipient CIS Number** – The DPW assigned Medical Assistance Management Information System (MAMIS) Client Information System (CIS) identification number by which the consumer is tracked in the MAMIS CIS. This number can be used within the CIS files using CQMENU to check current status of a waiver recipient.

**CIS Check** – A one-digit character DPW uses to indicate current status and verification of Medicaid consumers.

**Last Name** – This field will contain up to 14 characters of the waiver recipient's last name.

**First Name** - This field will contain up to 6 characters of the waiver recipient's first name.

**MA Recipient Number** – DPW assigned Medicaid recipient tracking number to show the current status, grant group, family status of recipients. This number can be used within the CIS files using CQMENU to check the current status of a waiver recipient.

**Provider ID Number** – The DPW assigned number identifying the MA enrolled provider who performed the procedure(s) identified by the claim. With this number, status, utilization and payments for specific providers can be checked.

**Date of Service** – This is the date service was provided to the waiver recipient as identified on the invoice sent to DPW.

**Date Adjudicated** – This is the date DPW completed processing the invoice and agreed to reimburse the provider for the service.

**Amount Paid** – This is the amount DPW reimbursed the provider for the invoiced service(s).

**Procedure Code** – This is the DPW assigned code used to identify the service provided to the recipient and being billed.

**Credit Code** – DPW uses a double entry bookkeeping system to track original and adjustments to paid claims. A credit code of "1" means an original claim, "2" means a cancellation of the original claim and "3" means this is the corrected version of the original invoice.

**Credit Description** – This is the meaning of the credit code provided in the previous column.

**Quantity Paid For** – This is the number of units of the service approved for payment in the paid claim.

**Provider Type** – This is the categorization of the provider by DPW. It is used to track which providers by type are providing waiver services to the recipients.

**Amount Billed** – This is the total amount billed by the provider in the invoice submitted to DPW for payment.

Attachment 1

Listed below is the detailed file description for use if importing this data set into Microsoft Access or other database software, either on a PC or mainframe.

| FIELD NAME | FIELD LENGTH | FLD TYP | DEC DGT | DEC PREC | FIELD TEXT DESCRIPTION |
|---|---|---|---|---|---|
| PSACODE | 2 | A | | | AAA Code |
| AAANAME | 40 | A | | | AAA Name |
| COUNCODE | 2 | A | | | County Code |
| COUNTYNAME | 20 | A | | | County Name |
| CISNBR | 9 | A | | | Recipient CIS Number |
| CHKDGT | 1 | A | | | CIS Check Digit |
| LASTNAME | 14 | A | | | Recipient Last Name |
| FRSTNAME | 6 | A | | | Recipient First Name |
| ORIGNBR | 16 | A | | | MA Recipient Number |
| PRVDRID | 7 | A | | | Provider ID Number |
| DATESVC | 8 | Date | | | Date Of Service |
| DATEADJUD | 8 | Date | | | Date Of Adjudication |
| AMOUNT | 9 | Signed | 9 | 2 | Amount Paid |
| PROCDOCE | 5 | A | | | Procedure Code |
| CREDITCODE | 1 | A | | | Credit Code |
| CREDITDESC | 15 | A | | | Credit Description |
| QNTYPAID | 4 | Signed | 4 | 0 | Quantity Paid For |
| PROVTYPE | 2 | A | | | Provider Type |
| AMTBILLED | 9 | Signed | 9 | 2 | Amount Billed |

Attachment 1

## Format for AAA Monthly Reconciliation Log

Waiver Paid Claims Reconciliation for PSA __ for (Month/Year)

| CISNBR | Provider | Proc Code | Date Served | Action Taken |
|--------|----------|-----------|-------------|--------------|
|        |          |           |             |              |
|        |          |           |             |              |
|        |          |           |             |              |
|        |          |           |             |              |
|        |          |           |             |              |
|        |          |           |             |              |
|        |          |           |             |              |

**CISNBR** is the 9-digit Client Identification Number assigned by DPW. This number is provided in the paid claim record in the field named CISNBR.

**Provider** is the DPW assigned provider identification number. This number is provided in the paid claim record in the field named PRVDRID.

**Proc Code** is the DPW assigned code used to identify the service, which was provided. This code is provided in the paid claim record in the field named PROCDOCE.

**Date Served** is the date the provider reported as the date on which the service was provided in the invoice submitted to DPW. This date is provided in the paid claim record in the field named DTESVC.

**Action Taken** is the response to the findings from the reconciliation. The responses will be one of the following:

**No Action Needed** – Upon reconciliation, it was determined there were no discrepancies.

**Billing Corrected** – It was determined that the provider had incorrectly billed for the service and an adjustment to the bill was submitted. Any necessary instructions regarding billing procedures for the provider were provided to preclude recurrence.

**Care Plan Corrected** – It was determined that the provider had billed correctly, but the care plan was incorrect. The care plan was corrected and the provider submitted a new invoice for services that had not been paid for. Any necessary instruction regarding care plan procedures for care managers was provided to preclude recurrence.

**DPW/BPI Notified** – It was determined that the provider had apparently intentionally erroneously billed for the service. The provider needs to be investigated by DPW/BPI to determine if this was an attempt at fraud and if this requires further action on the part of DPW. The AAA will make a separate determination as to whether this provider will continue as an AAA certified Waiver provider.

Attachment 2

## AAA Monthly Report to PDA

Waiver Paid Claims Report for PSA ____ for (<u>Month/Year</u>)

| Date | Received | Reconciled | Discrepancies | Provider | Care Plan | BPI |
|------|----------|------------|---------------|----------|-----------|-----|
|      |          |            |               |          |           |     |
|      |          |            |               |          |           |     |
|      |          |            |               |          |           |     |
|      |          |            |               |          |           |     |
|      |          |            |               |          |           |     |
|      |          |            |               |          |           |     |

**Date** is the month and year for which the reconciliation was done.

**Received** is the number of Paid Claims received in the download from PDA.

**Reconciled** is the number of Paid Claims that the AAA reconciled through the reconciliation process.

**Discrepancies** are the number of Paid Claims for which discrepancies were discovered during reconciliation.

**Provider** is the number of Paid Claims in which discrepancies were caused by the provider and appropriate corrective actions were taken.

**Care Plan** is the number of Paid Claims for which discrepancies were caused by the care plan and appropriate corrective actions were taken.

**BPI** is the number of Paid Claims in which the provider, apparently intentionally, billed erroneously and DPW/BPI needs to investigate.

Attachment 3

## AAA Report to DPW/LTC

Waiver Paid Claims Exception Report for PSA ____ (Month/Year)

| Provider | DOS | Recipient | Proc Code | Billed | Ordered | Overbill |
|----------|-----|-----------|-----------|--------|---------|----------|
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |
|          |     |           |           |        |         |          |

**Provider** is the 8 digit MA assigned provider identification code used by MAMIS. This is given in the paid claim.

**DOS** is the date of service for which the provider billed. This is given in the paid claim.

**Recipient** is the CISNBR of the consumer served. This is given in the paid claim.

**Proc Code** is the DPW assigned code for the service provided and billed. This is given in the paid claim.

**Billed** is the number of units of service or unit cost of services the provider billed for in the invoice submitted to DPW. Report the appropriate value depending upon the discrepancy. This is given in the paid claim.

**Ordered** is the number of units of service or unit cost of services the AAA authorized in the service order to the provider. Report the appropriate one depending upon the discrepancy. This is obtained from the local client records.

**Overbill** is the difference between what the provider billed and the AAA authorized which could not be resolved at the AAA level or which the AAA believes the provider intentionally overbilled.

Attachment 4

## PDA Quarterly Report to DPW/LTC

1) On a quarterly basis, PDA will submit to DPW/LTC a summary report of all Waiver reconciliation actions for the preceding quarter. This report will be statewide totals rather than a breakout by PDA of actions.

2) This report will provide the total claims received, total reconciled, and the findings and corrective actions taken for those with exceptions. It will be provided in the following format.

### Quarterly Waiver Reconciliation Report
### Statewide Activities

**Quarter** – This will be the quarter for which the report is submitted i.e. 3/00.

**Paid Claims** – This is the total number of Waiver paid claims statewide for the quarter being reported.

**Reconciled** – This is the total number of Waiver paid claims which were reconciled during the quarter being reported.

**Discrepancies** – This is the total number of Waiver paid claims reconciled in which discrepancies were found.

**Provider** – This is the number of Waiver paid claims with discrepancies in which the provider was at fault and appropriate adjustment documents have been submitted.

**Care Plan** – This is the number of Waiver paid claims with discrepancies in which the AAA care plan was wrong. The care plan has been corrected and the provider has submitted another invoice for unreimbursed billed services.

**BPI** – This is the number of Waiver paid claims with discrepancies for which the AAA suspects an intentional attempt on the part of the provider to bill for unauthorized services. These have been reported to BPI for investigation.