
BENEFICIARY FRAUD AND ABUSE POLICY AND PROCEDURES

REVISED 02/10/2021 - CHANGE NO. 04-21

Current Change Notice: 04-21

- General language/terminology throughout MA-3535 has been revised to replace/add:
 - Recipient to beneficiary.
 - References to County Department of Social Services/local DSS with local agency/agency.
 - Division of Medical Assistance to Division of Health Benefits (DHB).
 - References to legacy EIS and EPICS terminology with NC Fast terminology.
 - OVS included to all references for Online Verification System (OLV).
 - Division of Medical Assistance Program Integrity Coordinator with DHB Program Integrity Beneficiary Fraud Consultant.
 - Office of Compliance and Program Integrity telephone and fax numbers.
 - Family Planning Waiver with Family Planning Program.
 - References for all PI forms from DMA to DHB
 - PI report references from FRD to EPI.
- The following sections of MA-3535 have been amended:
 - II.C., corrects NC Administrative Code 10A NCAC 22F.0706.
 - III.D.1., adds the reference 108A-25 to Statutes Governing Confidentiality.
 - III.D.3, corrects the federal reference Section 1137(5)(A), 435.940ff.
 - V, V.A.1., V.A.3., and V.A.4.g., adds to the policy the various applications types.
 - V.A.2., adds the fraud prevention requirement to examine the case history and documentation prior to conducting a review.
 - VI.D. adds SCUBI, The Work Number and Asset Verification System (AVS) to computer matches.
 - VI.D.2, VII., and XIV., defines date of discovery for referrals, sets a time requirement for completion of investigations and claim establishments to within 180 days from the date of discover. For court case claims, 30 days from the court disposition.
 - VII.B. and VII.C., adds requirements to place all investigative documentation and evidence on the Investigative Case (IC) in NC Fast.
 - VIII.A.3.a., clarifies Earned/Unearned income reporting.
 - VIII.B.10 and VIII.B.11.c., clarifies FPP policy to include all ineligible individuals must be evaluated for FPP and provided an example for clarification.
 - VIII.D. removes reference to Work First Money Payment case.
 - VIII.A.12., removes reference to Buy-In for Part A and B.
 - IX.B.3., updates NCHC overpayment example.
 - VIII.C., introduces Modified Adjusted Gross Income (MAGI).
 - IX.A.B.3., updates calculation of NCHC overpayments example.
 - X.F.1., adds requirement for the DHB-7058 (Investigative Summary) to be attached to the NC Fast IC for unsubstantiated cases or the NC Fast Product Liability Case (PLC) for substantiated cases.
 - XI.1.b., adds requirement for the manual DHB-7059 (Notice of Change in Overpayment for Medical Assistance) to be attached to the NC Fast PLC.
 - XII., adds policy for Voluntary Repayment Agreement negotiations to be repaid in full within 36-60 months. Also, adds hardship clarification.
 - XVI.E(3).b., updates valid statuses for the NC Debt Setoff/Intercept screen.
 - XVIII.A. clarifies the purpose of the beneficiary profile.
 - XVIII.A.3., removes reference to Profiles prior to July 1, 2010.

- XVIII.B.2.b., updates policy to include when and where beneficiary profiles requested for fraud cases are available in NCTRACKS.
- XVIII.D.1.c., adds reference to the Payment Summary page of profile and what is listed on the page.
- XVIII.D.2., updates policy to reflect NCTRACKS retains claims history for 10 years from the date of payment for most claims.
- XVIII.D.3., updates policy to reflect claims information included on the beneficiary profile.
- XVIII., updates the Claim Page Header Descriptions, Claim Types, Claim Status and Medicaid Service Codes. Also adds examples for Provider Summary Information, Payment Summary, and Date of Service Summary.
- XVIII.F.3., updates made to examples for Provider Summary Information, Payment Summary, Date of Service Summary.
- XVI.F.6., adds Cross Reference ID Summary and example.
- XVII., corrects federal citation for Social Security Act 1137, 435.940ff.
- Program Integrity forms have been updated as follows:
 - All forms are interactive.
 - Replaces terminology for EIS or EPICS with NC Fast terminology.
 - Replaces recipient with beneficiary.
 - Changes references for County Department of Social Services to local agency/agency.
 - Makes all PI forms begin with DHB instead of DMA.
 - **DHB-7059** (Notice of Change in Medicaid Overpayment), includes additional reasons for a change in the overpayment amount and/or period.
 - **DHB-7063** (Medicaid/ NCHC Beneficiary Profile Request), provides current contact information for DHB OCPI.
 - **DHB-7097** (Beneficiary Request and Authorization to Disclose Health Information), adds Beneficiary to the title of form.
 - **DHB-7098** (Local Agency Request and Authorization to Disclose Health Information), adds Local Agency to the title of form.

I. PURPOSE

This section provides procedures to comply with Federal and State Medicaid requirements regarding potential fraud and misrepresentation that results in medical assistance overpayments. Although methods for handling cases may vary between **local agency**, disposition and reporting of these cases must be consistent.

II. LEGAL RESPONSIBILITY AND REFERENCES

Both the state and the **local agency** have a legal obligation to assure proper administration of public funds and an obligation to take necessary legal steps in cases of fraud or misrepresentation. This obligation rests on the efficiency, thoroughness and integrity of the processes by which initial and continuing eligibility are determined.

- A. Social Security Act, Title XIX, Section 1909 and the implementing Federal Regulations 42 CFR Part 455 entitled "Program Integrity-Medicaid" set forth the requirements for the control of fraud and abuse in the Medicaid program by the state Medicaid agency, the Division of Health Benefits (DHB).**
- B. North Carolina Administrative Code 10 NCAC 22F.0103 sets forth the procedures to prevent, detect, investigate, report, identify and collect all improper payments, and to impose administrative measures for the control of fraud, abuse and over-utilization practices by providers and recipients.**

C. North Carolina Administrative Code **10A NCAC 22F.0706** contains procedures established by **DHB** regarding recipient fraud and abuse. This Section contains requirements for the prevention, detection, investigation, referral, prosecution, and recoupment of overpayments, and for the reporting of fraud, abuse and over-utilization. These procedures are supervised by **DHB** and administered by each **local agency**. Also included are the procedures for the equitable distribution of overpayments collected in cases involving overpayments in more than one assistance program.

III. NORTH CAROLINA GENERAL STATUTES

Following are the General Statutes Applicable to Medical Assistance Fraud/Abuse:

- A. North Carolina General Statute 108A-64, Medical Assistance Recipient Fraud. This statute should be used when prosecuting fraud in the Medicaid program. It shall be unlawful for any person to knowingly and willfully and with intent to defraud make or cause to be made a false statement or representation of a material fact in an application for assistance under this part or intended for use in determining entitlement to such assistance.**

It shall be unlawful for any applicant, recipient or person acting on behalf of such applicant or recipient to knowingly and willfully and with intent to defraud, conceal or fail to disclose any condition, fact or event affecting such applicant's or recipient's initial or continued entitlement to receive assistance under this part.

It is unlawful for any person knowingly, willingly, and with intent to defraud, to obtain or attempt to obtain, or to assist, aid, or abet another person, either directly or indirectly, to obtain money, services, or any other thing of value to which the person is not entitled as a recipient under this Part, or otherwise to deliberately misuse a Medicaid identification card. This misuse includes the sale, alteration, or lending of the Medicaid identification card to others for services and the use of the card by someone other than the recipient to receive or attempt to receive Medicaid program coverage for services rendered to that individual.

Proof of intent to defraud does not require proof of intent to defraud any particular person.

1. **Felony:** A person who violates a provision of this section shall be guilty of a Class I felony if the value of the assistance wrongfully obtained is more than four hundred dollars (\$400.00).
2. **Misdemeanor:** A person who violates a provision of this section shall be guilty of a misdemeanor if the value of the assistance wrongfully obtained is four hundred dollars (\$400.00) or less.

For the purposes of this section the word "person" includes any natural person, association, consortium, corporation, body politic, partnership, or the group, entity or organization.

- B. North Carolina General Statute 108A-70.28, Fraudulent Misrepresentation, can be used when prosecuting fraud cases for the North Carolina Health Choice (NCHC) program. It shall be unlawful for any person to knowingly and willfully, and with intent to defraud, make or cause to be made a false statement or representation of a material fact in an application for coverage under this Part or intended for use in determining eligibility for coverage. It should be noted that prosecution under this statute are felonies regardless of the amount involved.**

It shall be unlawful for any applicant, recipient, or person acting on behalf of the applicant or recipient to knowingly and willfully, and with intent to defraud, conceal, or fail to disclose any condition, fact, or event affecting the applicant's or recipient's initial or continued eligibility to receive coverage or benefits under this part.

It is unlawful for any person knowingly, willingly, and with intent to defraud, to obtain or attempt to obtain, or to assist, aid, or abet another person, either directly or indirectly, to obtain money, services, or any other thing of value to which the person is not entitled as a recipient under this part, or otherwise to deliberately misuse a NCHC identification card. This misuse includes the sale, alteration, or lending of the NCHC identification card to others for services and the use of the card by someone other than the recipient to receive or attempt to receive NCHC program coverage for services rendered to that individual.

Proof of intent to defraud does not require proof of intent to defraud any particular person. A person who violates a provision of this section shall be guilty of a Class I felony.

For purposes of this section the word "person" includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity, or organization.

C. North Carolina General Statute 14-100 Obtaining Property by False Pretense can be used when prosecuting fraud cases in all social services programs. It should be noted that cases prosecuted under this statute are felonies regardless of the amount involved.

If any person shall knowingly and designedly by means of any kind of false pretense whatsoever, whether the false pretenses of a past or subsisting fact or of a future fulfillment or event, obtains or attempts to obtain from any person within this state any money, goods, property, services, chose in action, or anything of value with intent to cheat or defraud any person of such money, goods property, services, chose in action or other thing of value,

Provided, that if, on the trial of anyone indicted for such crime, it shall be provided that he obtained the property in such manner as to amount to larceny or embezzlement, the jury shall have submitted to them such other felony proved; and no person tried for such felony shall be liable to be afterwards prosecuted for larceny or embezzlement upon the same facts:

Provided further that it shall be sufficient in any indictment for obtaining or attempting to obtain any such money, goods, property, services, chose in action, or other thing of value by false pretenses to allege that the party accused did the act with intent to defraud, without alleging an intent to defraud any particular person, and without **alleging any ownership of the money, goods, property, services, chose in action or other thing of value**; and upon the trial of any such indictment, it shall not be necessary to prove either an intent to defraud any particular person or that the person to whom the false pretense was made was the person defrauded, but it shall be sufficient to allege and prove that the party accused made the false pretense charged with an intent to defraud. If the value of the money, goods, property, services, chose in action, or other thing of value is one hundred thousand dollars (\$100,000) or more, a violation of this section is a Class C felony. If the value of the money, goods, property, services, chose in action, or other thing of value is less than one hundred thousand dollars (\$100,000), a violation of this section is a Class H felony.

Evidence of non-fulfillment of a contract obligation standing alone shall not establish the essential element of intent to defraud.

D. Statutes of Limitations

When referring cases for prosecution in either criminal or civil court, the **local agency** must be aware of the statutes of limitations that apply to these cases. These statutes affect the amount of overpayment presented in court and the specific charges brought against the **beneficiary**.

1. **Criminal Statute - North Carolina General Statute 15-1** is the statute of limitations for criminal misdemeanors. This statute allows prosecution action of misdemeanors to be taken no later than two years after the fraudulent act occurred.

A misdemeanor under the current **North Carolina General Statute 108A-64**, are cases involving \$400.00 or less.

2. **There is no statute of limitations for felonies, that is, cases involving over \$400.00.** However, prior to July 1, 1977, all fraud cases against the Medical Assistance program were misdemeanors. Therefore, for cases in which a fraudulent act was committed prior to July 1, 1977, the criminal statute of limitations has expired regardless of the amount of the overpayment for that act. The North Carolina Attorney General's Office has rendered the opinion that an act is determined as the initial false statement, misrepresentation, and/or omission of fact, running to the next recertification or contact with the client at which time false statement, misrepresentation, and/or omission of fact could have been corrected. Each certification period or period between contacts, thereafter, during which time the recertification, misrepresentation, and/or omission of fact is perpetuated, is considered a separate offense.

Therefore, in cases involving overpayments made prior to July 1, 1977, if a recertification period began prior to July 1, 1977, and continued after that date, that specific recertification period would not be prosecutable in criminal court regardless of the amount as the statute of limitations has expired.

3. **Civil Statute** - The civil statute of limitations, **North Carolina General Statute 1-52**, runs for three years from the date the act is discovered, or should have been discovered through the exercise of reasonable care.

If the recipient has signed a repayment agreement containing the word "Seal" next to the signature, the civil statute of limitations for enforcement of collection is ten years from the date the document was signed. However, the client must circle the word "Seal." The investigator should contact the **local agency** attorney for further information regarding this point.

E. Statutes Governing Confidentiality

1. **General Statute 108A-80, 143B-153, 108A-25** requires each **local agency** is responsible for developing a confidentiality policy that is consistent with state law. (See **MA-3500, Confidentiality**.) According to the Attorney General's office, investigators are bound by the same rules of confidentiality as are other staff members of the **agency**. Therefore, it is necessary for each investigator to have discussed these statutes with their agency's county or agency legal counsel.
2. **Section 1902(a)(7) of the Social Security Act** requires a State plan that provides safeguards to restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan. This subpart specifies State plan requirements, the type of information to be safeguarded, the conditions for the release of safeguarded information and restrictions of the distribution of other information.
3. **Section 1137(5)(A), 435.940ff of the Act**, which requires agencies to exchange information in order to verify income and eligibility of applicants and beneficiaries, also requires State agencies to have adequate safeguards to assure that:

- a. Information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information, and information received under section 6103(l) of the Internal Revenue Code of 1954 is exchanged only with agencies authorized to receive that information under that section of the Code, and
- b. The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

Source: As re-designated, 44 FR 17926 (March 23, 1979) and amended at 51 FR 7178 (February 28, 1986, effective May 29, 1986)

4. **42 CFR 431.301** State Plan Requirements

A State Plan must provide, under a State statute that imposes legal sanctions, safeguards meeting the requirements of this subpart that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan.

Source: As re-designated, 44 FR 17926 (March 23, 1979)

5. **42 CFR 431.302** Purposes directly related to State Plan administration include:
 - a. Establishing eligibility
 - b. Determining the amount of medical assistance
 - c. Providing services for **beneficiaries**

- d. Conducting or assisting an investigation, prosecution or civil or criminal proceeding related to the administration of the plan.

Source: As re-designated, 44 FR 17926 (March 23, 1979)

6. **42 CFR 431.303** State Authority for Safeguarding Information

The Medicaid agency must have authority to implement and enforce the provisions specified in this subpart for safeguarding information about applicants and beneficiaries.

Source: As re-designated, 44 FR 17926 (March 23, 1979)

7. **42 CFR 431.304** Publicizing Safeguarding Requirements

The agency must publicize provisions governing the confidential nature of information about applicants and beneficiaries, including legal sanctions imposed for improper disclosure and use.

The agency must provide copies of these provisions to applicants and beneficiaries and to other persons and agencies to which information is disclosed.

Source: As re-designated, 44 FR 17926 (March 23, 1979)

8. **42 CFR 431.305** Types of Information to Be Safeguarded

The agency must have criteria that govern the types of information about applicants and beneficiaries that are safeguarded. This information must include at least:

- a. Names and addresses
- b. Medical services provided
- c. Social and economic conditions or circumstances
- d. Agency evaluation of personal information
- e. Any information received for verifying income eligibility and amount of medical assistance payments (see 435.940 ff). Income information received from SSA or IRS must be safeguarded according to the requirements of the agency that furnished the data.

9. **Legal Restrictions**

The Privacy Act permits a **beneficiary** to have some control over the accuracy and disclosures of records maintained by Federal Agencies. However, the Privacy Act of 1974 (P.L. 93-579) Section 552b (7) allows a fraud investigator to obtain information necessary to conduct a civil or criminal investigation.

The **beneficiary** and legal counsel have the legal right to view and have a copy of the information in the eligibility or services record at any time with the exception of:

- a. Information that the **local agency** is required to keep confidential by state or federal statute or regulation.
- b. Confidential information originating from another source.
- c. Information that would breach another third party's right to confidentiality. (Reference: 10 NCAC.24B .0306 and 20 NCAC.32S .0306)
- d. Investigative records.

IV. FRAUD VS. MISREPRESENTATION

A. General

Although fraud is a question for the courts to determine, the **agency** must determine whether there is a basis for belief that fraud may have been committed. In making this decision, intent and the mental competency of the **beneficiary** must be considered. Also, a clear distinction, based on verified facts, must be made between misrepresentation with intent to defraud and misstatements due to the misunderstanding of eligibility requirements or of the responsibility for providing the **agency** with information.

It is also important to distinguish between intent to defraud and omission, neglect, or error by the **agency** in helping a **beneficiary** to understand his responsibilities and in securing and recording pertinent information.

B. Fraud vs. Misrepresentation

1. Fraud

Fraud is, by law, a crime against society that can only be determined in a criminal court. It is the willful and intentional act that creates the crime, rather than the resulting overpayment.

- a. For Medicaid purposes the following definition of "client" applies throughout this policy.

Client – The **beneficiary**, parents and/or financially responsible adults of a minor child, legal spouse of a **beneficiary**, or a representative acting in behalf of a **beneficiary**. They may all be debtors except a minor child.

All debtors are jointly and separately liable for the medical assistance overpayment.

- b. A client is suspected of fraud when the client willfully and knowingly and with the intent to deceive:

- (1) Makes a false statement or misrepresentation; or
- (2) Fails to disclose a material fact; or
- (3) Does not report changes in income or other eligibility factors that affect the benefit; and
- (4) As a result, obtains, attempts to obtain or continues to receive assistance.

2. Misrepresentation

Misrepresentation causes monetary loss as a result of a client's action or inaction. Misrepresentation can be intentional or unintentional.

- a. Intentional misrepresentation - The client gives incorrect or misleading information in response to either oral or written questions. The information is provided with the knowledge that it is incorrect, misleading or incomplete. **This is suspected fraud until decided by a court of law.** If the court determines that the recipient is guilty of an Intention Program Violation (IPV) claim would be established in the [NC FAST Program Integrity \(PI\) Portal](#).
- b. Unintentional misrepresentation - There is no proof that the client acted willfully and intentionally to obtain more benefits than those to which he was entitled. The client gives incomplete, incorrect or misleading information because he does not understand the eligibility requirements or his responsibilities to provide the [local agency](#) with required information. For these situations, an Inadvertent Household Error (IHE) claim would be established in the [NC FAST PI portal](#).

3. Criteria for Fraud

To have a cause for action for fraud in public assistance cases, there must be proof of a statement made by the client, and the following conditions must be found with regard to such statement:

- a. The statement is false; and
- b. The client knows that the statement is false, or the client makes the statement recklessly and with knowledge of the truth or falsity of the statement; and
- c. The statement is made by the client, with the intent that it will be relied on by the [local agency](#), and that it will induce the [agency](#) to authorize assistance to which the recipient is not entitled or to assistance greater than that to which the recipient is entitled; and
- d. The [agency](#) does in fact rely upon the statement given by the client, and awards assistance to which the applicant/beneficiary is not entitled or assistance greater than the applicant/beneficiary is entitled; and

- e. The **agency** has informed the client, of the law relating to fraud and appropriate information has been entered in the agency record; and
- f. The applicant/beneficiary has signed a statement that all information given by the applicant/beneficiary and/or their representative pertaining to their eligibility is correct and true to the best of their knowledge.

V. PREVENTION

A. Interviewing

1. A key to fraud prevention is skillful interviewing during the **face to face or telephone application process**. It is also important to use fraud prevention methods found in this section during the evaluation of mail-in, faxed and online applications, at reviews and when changes in situation are reported.
2. **Prior to conducting a review, examine the case history and documentation**. Take note of previous work history, income, prior reserve (such as bank accounts, insurance policies, etc.) and other eligibility factors.
3. The **face to face interview or telephone** contact involves two-way communication. Be specific and thorough in the questions asked. Phrase questions in a way the applicant will understand. Give the applicant a chance to respond in their own words. Listen carefully to the applicant's responses. Ask specific follow up questions, evaluate their reaction and document the responses.
4. Follow these steps at interviews:
 - a. Explain to the applicant his obligation to report all changes in situation within ten (10) calendar days after they occur.
 - b. Inform the applicant of the consequences of failure to report changes. Stress the penalties for fraud and misrepresentation.
 - c. Explain to the applicant how to report changes and the required time frame for reporting changes.
 - d. Inform the applicant about computer matches in which the **local agency** participates.
 - e. Explain the meaning of fraud. Give the applicant a copy of the fraud form, [DSS-8627](#).
 - f. If the applicant living standards appear to exceed their income, question the applicant regarding unreported income.
 - g. **If conducting a face to face or telephone review**, ask the **beneficiary** about any changes that have occurred since application or the last review.

B. Documentation and Verification

Thorough documentation and verification provide the caseworker necessary information for the next review or for a possible fraud case and avoids erroneous eligibility decisions and undetected cases of fraud. The following procedures are recommended at all applications and reviews as a method of fraud prevention:

1. Complete an **Online Verification System/Online Verification (OVS/OLV)** inquiry to ensure each applicant/beneficiary does not already receive assistance in your **local agency or another agency**. Document the results of the inquiry.
2. Complete all available on-line inquiries, using all social security numbers provided. Check all matches.
3. Document and verify all eligibility factors as required in policy.
4. When a change is anticipated, flag the case for review.

C. Other Preventive Measures

1. Intra-agency
 - a. Establish communications among the various units in the **local agency**. Fraud prevention is the responsibility of the entire agency, so developing a systematic way to report changes and exchange information is key.
 - b. It is advised that the Program Integrity team conduct periodic training to educate **agency** employees who work in benefits eligibility, and in services, regarding what Program Integrity does. Training should include the following:
 - (1) Interviewing skills and techniques.
 - (2) What constitutes misrepresentation and/or fraud.
 - (3) How to report suspected fraud and/or misrepresentation to Program Integrity staff.
 - (4) The difference between a front-end referral and a regular referral.
 - (5) An overview of what steps the investigator takes when investigating a referral.
 - c. **It is also recommended that each agency devise a plan to ensure that every caseworker and social worker involved with a beneficiary/ family communicate changes in the situation to each other in an effort to prevent agency responsible errors.**

2. Inter-agency

To obtain prompt and accurate information needed to determine eligibility, it is important to establish a good working relationship with other agencies, employers and institutions. Inform them of the program requirements and the importance of receiving prompt and accurate information.

3. Public awareness

Informing the public about your **local agency** attempts to prevent fraud and abuse is important, both as a deterrent and as a public relations measure. Information regarding court actions, amount of recoupments, etc., should be made public. Publicize the phone number to call to report cases of possible fraud and abuse, stressing that such reports are confidential. If the public realizes they will be supported in their efforts, the **agency** may be able to obtain much more information and cooperation.

VI. DETECTION

Referrals for investigations are received from the following:

A. State Office Referrals

Any leads received by **DHB** will be referred to the **agency** in writing for investigation. The **agency's** PI investigator should enter a pending referral in **NC FAST** **within seven days** of the referral. If an IPV or an IHE is established; create a claim in **NC FAST** to agree with the findings. Follow the instructions in the **NC FAST job aids, PI-Create Referrals/Investigation Cases and PI-Establish a Claim/Product Liability Case.**

Regardless of the results of the investigation, the **agency** must provide the **referring DHB Program Integrity Beneficiary Fraud Consultant** with a copy of the **Investigative Summary (DHB-7058), of the investigation within 60 days** from the date of the referral letter.

B. Quality Assurance Reviews

During their regular review, **DHB Office of Compliance and Program Integrity/Quality Assurance** staff sometimes detects possible fraud or misrepresentation. Cases found suspected of fraud or misrepresentation will be referred to the **agency's PI Unit** by the assigned **DHB PI Beneficiary Fraud Consultant** for further investigation.

The PI Unit must enter a pending **Medicaid** referral in the **NC FAST PI portal** **within seven days** of date of the referral. A copy of the **DHB-7058, Investigative Summary**, of the investigation must be sent to the referring **DHB PI Beneficiary Fraud Consultant** **within 60 days** from the date of the referral letter.

C. Private Sector and Other Agencies

If you receive information from other agencies, institutions, providers, other **beneficiaries** or private citizens, you are required to investigate the lead. Emphasize that such reporting will

be kept confidential. Some people may be reluctant to report suspected cases of fraud if they feel their names will be disclosed.

D. Local Agency Staff

During the application and review processes, the **local agency's** staff may discover cases of possible fraud, abuse, or misrepresentation that need to be evaluated and/or investigated for a possible overpayment. At this point a PI referral should be keyed in **NC FAST using the job aid, PI-Create Referrals/Investigation Cases**. There are two types of in-house referrals:

1. **Front-end Referral:** This referral is made during the application or recertification process prior to disposition/recertifying. It is made to prevent the release of erroneous issuance due to potential fraud. Usually the investigator has **five workdays** to complete this investigation and instruct the worker on their findings.
2. **Regular Referral:** This referral is made at any time other than during the initial application/recertification process. When a case is in active status; however, consideration should be given to cases still currently potentially ineligible to prevent further overpayments. **The Investigator has 180 days from the date of referral to complete.**

E. Other sources include but are not limited to:

1. Computer matches in **OVS/OLV** such as **NC FAST, ACTS, SOLQ, ESC/SCUBI, SDX, BENDEX, NEW HIRE, The Work Number, Asset Verification System (AVS)**, etc. Also check FRR (Financial Resource Report), BEER (Beneficiary Earnings Exchange Report) and the Veteran's Affairs matches.
2. Tax records (unreported personal property, automobiles, farm equipment)
3. Register of Deeds, and Clerk of Court records (marriage, transfers of property)
4. Social Security records (increases, lump sum payments, dual benefits)
5. Department of Motor Vehicles (DMV) records (vehicle license check, unreported registered vehicles, address)
6. Court records (support agreements, divorce decrees, prior convictions)
7. **Department of Public Safety (DOC/NC DPS)** records (incarceration, parole, probation, work release)
8. HUD records (household composition, reported income)
9. School records (address, household composition, responsible party)
10. Utility company records (address, responsible party)

11. Collateral contacts (Landlords, neighbors, relatives)
12. Newspaper reports (births, deaths, marriages and transfers of property)

VII. INVESTIGATIONS

Local agencies must take prompt action to address all complaints of suspected Medicaid fraud the agency receives and recover any established overpayments.

The **date of discovery** is the day that PI receives the referral. **All investigations and establishment of claims should be completed within 180 days of the date of discovery. Claims for court cases must be established within 30 days of the court's decision.**

A. Preliminary Investigation

When a referral for possible Medicaid fraud or misrepresentation is received from any source or when there is an indication a **beneficiary** may have received benefits to which he was not entitled, the **local agency** must conduct a preliminary investigation to assess whether eligibility has been correctly determined and documented according to policy regulations. They must also establish a pending claim in **NC FAST**. **Follow the instructions using the job aid, PI – Creating Referrals/Investigations Case.**

1. Review **all agency** benefits case records and systems (**OVS/OLV**, etc.) for the **beneficiary**, including Medicaid (MA), Work First Family Assistance (WFFA), and Food and Nutrition Services (FNS), Child Care, etc. These records should furnish basic information and clearly show the findings on all eligibility factors. Talk to any Service Workers to determine if there was any information reported to them that would have affected eligibility.
2. It is necessary to ensure that the **beneficiary** understood and accepted responsibility for reporting changes in circumstances to the **agency** in a timely manner.
 - a. Determine from documentation and verification documents that adequate explanations were provided to the **beneficiary** regarding his rights and responsibilities.
 - b. Determine whether the **beneficiary** was offered assistance with obtaining requested verifications at each contact with the **local agency** during the application or recertification process. This is necessary to ensure that the **beneficiary** understood and accepted responsibility for reporting changes to the **agency** in a timely manner.
 - c. **If the agency did not meet their obligation, any resulting overpayment is deemed an agency error and cannot be collected from the beneficiary.**
3. Determine from the case if the information is already known to the agency.

- a. Information reported in a timely manner to **any agency's** staff is considered information known to the agency.

An overpayment resulting from information known to the agency, but not communicated to the appropriate case workers is deemed an Agency Error (AE) and cannot be recouped from the beneficiary. An AE claim should NOT be created claim in NC FAST.

- b. Caseworkers that worked the case during the period in question are invaluable assets when conducting the investigation. Discussion with them may clarify documentation and/or other critical points.
4. If the preliminary investigation establishes the **beneficiary's** continuing eligibility, no further investigation is required.

Example: A private citizen calls to report that a **beneficiary's** husband is employed. A review of the case indicates that his income was reported and considered in determining her eligibility, or the change in income did not affect the family's eligibility.

5. If the preliminary investigation gives the **agency** reason to believe fraud or misrepresentation has occurred, **create an Investigative Case in NC FAST** and conduct a full investigation. Refer to the **NC FAST job aid, PI-Creating Referrals/Investigation Cases** for instructions.

B. Verification of Reported Information

Continue a full investigation until legal action is initiated, the case is resolved by seeking recoupment of the overpayment, or the case is closed due to insufficient evidence to support the allegations, or for other reasons.

1. Verify the reported information to establish whether fraud/misrepresentation exists. Obtain the verifications by written or verbal contact with the **beneficiary**, employers, financial institutions, other agencies, and collaterals, etc.
2. Document all actions on the **Notes tab of the NC Fast Investigative Case (IC)**. Include complete names and dates.
3. If you are unable to substantiate the allegations, **document your findings on the Notes tab of the IC** and close the investigation as unsubstantiated. Refer to the **job aid, PI-Creating Referrals/Investigation Cases** for instructions.
4. If verifications substantiate that fraud/misrepresentation exists, schedule an interview with the beneficiary.

C. Building the Investigative Case

To build an investigative case (IC), clearly document each step taken in the application/authorization process on the **Notes tab of the IC**.

Certain information needs to be **attached to the IC** when available, including, but not limited to the following:

1. All application and recertification **paper copies or NC FAST attachments**.
2. All narratives pertaining to the overpayment from the paper eligibility file **and/or those listed on the NC FAST Insurance Affordability case, Income Support case, Income Support case, and PDC(s)**.
3. Calculations of benefits.
4. All supporting verifications to include, but not limited to the following:
 - a. Wage stubs and/or affidavits
 - b. Bank records, and court documents
 - c. Collateral statements, postal letters
 - d. All computer matches
5. An investigative narrative should be kept on the **NC FAST IC** of every contact with the **beneficiary** and on any action taken on the case. Record the date of contact on the entry if not entered the same day. Use full sentences and quote what was actually stated whenever possible. Do not enter any opinions.
6. Be sure you have reviewed all benefit **cases (paper and electronic)** in your agency to determine what information the **beneficiary** provided, and what was verified. Also, communicate with Service Workers.

Remember, if the **beneficiary** reported something to **anyone** within the **local agency**, it is considered as "known to the agency". If the **agency** failed to follow up in a timely manner, any resulting overpayment is considered an agency error. Medicaid policy prohibits collecting these types of overpayments from the **beneficiary**.

D. Investigative Interview

1. Conduct an interview with the **beneficiary** and/or representative if a case appears to be **beneficiary** responsible fraud or misrepresentation.
2. The investigative interview with a **beneficiary** suspected of fraud or misrepresentation can be the most important element of the investigation. It is important to employ techniques of skillful interviewing.
 - a. Interview the **beneficiary** and/or representative in an area where you will have privacy. Inform the **beneficiary** they are free to leave at any time.

- b. Inform the **beneficiary** and/or representative you are investigating for possible overpayments. Ask the **beneficiary** and/or representative if there is anything, they wish to tell you that they have not previously revealed to the **agency**.
- c. Discuss the subject of fraud. Explain the beneficiary's and/or representative's rights and responsibilities to determine if the **beneficiary** understands the concept of fraud. Ask the **beneficiary** and/or representative to explain their rights and responsibilities in their own words.
- d. Review the case record with the **beneficiary** and/or representative. Cover the eligibility points in question. Confirm that the **beneficiary** and/or representative made an application and did in fact make the statements documented on the signed form(s).
- e. Ask again if the **beneficiary** and or representative wishes to change any of the statements made or if they have any new information to report.
- f. Use open-ended questions and mirror questions. Allow the **beneficiary** or representative as much time as needed to answer.

Example: "How did you say you disposed of the property?" "Help me understand your statement about your income and why you did not report it."

- 3. When the **beneficiary** and/or representative continues to affirm that all statements previously made are true, confront the **beneficiary** and/or representative with the known facts.
 - a. If the **beneficiary** and/or representative makes a statement that is known to be false, present the known facts as well as any evidence gathered to substantiate them.
 - b. If the **beneficiary** and/or representative admits wrongdoing and wishes to acknowledge the truth, take a written statement and have the **beneficiary** and/or representative sign and date it. It is recommended that a witness also sign the statement. Also, review the case record and have the **beneficiary** and/or representative identify those statements that are false.
- 4. Document the interview thoroughly.

VIII. CALCULATING OVERPAYMENTS

This section provides rules for establishing overpayments and is applicable to all Families and Children coverage groups. To properly determine an overpayment, the investigator must have full knowledge of all Medicaid programs and must have access to present and past eligibility policy.

A. General Rules

1. Based on the verified unreported information, determine the period(s) of ineligibility for each assistance unit (a.u.) member. The period of ineligible may encompass a whole or partial certification period (c.p.). Children receiving MIC/NC Health choice are entitled to continuous eligibility for one year, changes in income do not affect their eligibility.
2. Redetermine eligibility as if **all verified** information had been reported timely by the **beneficiary**.
3. Allow time changes:
 - a. **Earned income changes must be reported within 10 calendar days of beginning the changed employment or earnings.**
 - b. **Unearned income changes must be reported within 10 calendar days of receipt of the changed income.**
 - c. Allow another 10 workdays for the Timely Notice ([DMA-8110](#)) to the client of the change in eligibility.
4. Use the appropriate income/resource limits in effect at the time of the period of ineligibility.
 - a. For cases with unreported/changed resources verify available resources for each month of the c.p.
 - b. For cases with unreported/changed income, compute eligibility separately for each certification period, using the verified base period income, and project it over the remainder of the c.p. as if the income had been reported timely by the **beneficiary**.
 - c. If multiple changes occur, re-budget each change in the order in which it occurred. Refer to [MA-3300 Income](#) for an explanation of what constitutes a change in income.
5. Evaluate for Job Bonus.

Do not evaluate for Job Bonus after January 1, 2014.
6. Always evaluate eligibility according to the policy requirements for Extended Medicaid before establishing an overpayment. Extended Medicaid includes Transitional Medicaid.
7. If any a.u. member is determined ineligible under the original coverage group, determine if the a.u. member could have been eligible under any other coverage group if the information had been reported correctly and timely.

Example: A a.u. member who is ineligible as Categorically Needy (CN) may be eligible as Medically Needy (MN) with a deductible.

Example: A a.u. member who is ineligible for MAF may be eligible for MPW or FPP.

8. Evaluating a Medicaid case for NCHC eligibility will not prevent an overpayment for Medicaid since each program has a separate federal funding source.

Example: A a.u. member who is ineligible for MIC-N may be eligible for **MIC1/NCHC**; however, he will still have a Medicaid overpayment.

9. Evaluating a NCHC case for Medicaid eligibility will not prevent an overpayment for NCHC since each program has a separate federal funding source.

Example: A a.u. member who is not eligible for NCHC may be eligible for MAF-M; however, he will still have an NCHC overpayment.

10. Family Planning Program

Beneficiaries who are ineligible for full Medicaid or other limited coverage Medicaid must be evaluated for FPP and meet all financial and non-financial eligibility requirements. The beneficiary cannot have been pregnant during the period of ineligibility.

11. For Medicaid cases, once the verified period of ineligibility is established, request a Medicaid/NCHC **Beneficiary** Profile from **Division of Health Benefits (DHB)** on the DHB-7063, in order to establish the overpayment amount.

Complete the required information for each ineligible **beneficiary**. (For instructions on how to order Medicaid/NCHC Beneficiary Profiles, refer to XVIII. below.)

- a. It is not necessary to request a profile for long-term care cases with an understated liability.
- b. Do not order a Medicaid/NCHC **Beneficiary** Profile for NCHC claims prior to July 1, 2010. Refer to XVIII. below, for instructions regarding the overpayment procedures for NCHC claims.
- c. For a MAF-C/N **beneficiary** who is found eligible for FPP, check the FPP block and indicate the dates of eligibility on the profile. **DHB** staff will identify which claims are for FPP services and the amount to exclude from the total claims paid for Medicaid services during the period of ineligibility.

Example: A beneficiary is found ineligible for MAF-C during the period 1/2019 – 12/2019, but eligible for FPP (MAF-D) coverage. An FPP profile is requested. Total claims paid were \$5,000. Per the letter from DHB, there were \$545 in FPP services received during the period requested. The FPP services are excluded from the total claims paid. The total overpayment is \$5,000 - \$545 = \$4,455.

B. Overpayment Methodology for New or Additional Deductible Due to Excess Income

1. When unreported income is discovered, it may result in the **beneficiary** having to meet a new or additional deductible. Refer to section [MA-3315 Medicaid Deductible](#), to determine which medical expenses can be applied towards the deductible. **Children receiving MIC/NC Health choice are entitled to continuous eligibility for one year, changes in income do not affect their eligibility.**
2. Determine the period(s) in which the **beneficiary** was ineligible for CN coverage due to income that exceeded the income limit.
 - a. The period of ineligibility for may encompass a whole or partial c.p., several contiguous c.p.'s, or in the case of multiple changes in income, there may be non-contiguous periods of ineligibility.
 - b. In determining the point of beginning ineligibility, allow adequate time for changes to have been reported, and for appropriate action to have been taken by the local agency.
3. Change in Current Certification Period
 - a. Verify and project changed, or unreported income based on policy requirements.
 - b. If the **beneficiary** is currently on a deductible that has not been met, send a timely notice to increase the deductible. As there has been no authorization, there is no overpayment.
 - c. If the **beneficiary** is authorized because there is no current deductible or the current deductible has been met, and there is time in the current certification period (c.p.) to take action to revise the deductible, send timely notice to increase the deductible.
 - (1) If the **beneficiary** incurs enough medical expenses to meet the additional deductible prior to the end of the c.p. (including old bills), there is no overpayment.
 - (2) If the **beneficiary** does not incur enough medical expenses to meet the additional deductible, apply all allowable expenses to the additional deductible to determine the amount of the unmet deductible.
 - (3) Request a Medicaid/NCHC **Beneficiary** Profile for the period authorized.

Refer to section XVIII. below, for instructions on how to read Medicaid/NCHC **Beneficiary** Profiles and determine the amount of claims paid on behalf of the client during the period of ineligibility.
 - (4) If a **beneficiary** is eligible for FPP coverage, subtract out all Family Planning services from the total claims paid to determine the total amount of expenses Medicaid paid.

- (5) Compare the amount of the unmet deductible to the amount of expenses paid by Medicaid. The overpayment is the lesser of the two amounts.
4. If the change is discovered after the c.p., or it is too late in the current c.p. to take action to revise the deductible, determine the overpayment as follows:
 - a. Verify and project changed, or unreported income based on policy requirements.
 - b. If the original deductible was never met and there was no authorization, there is no overpayment.
 - c. If the original deductible was met or the **beneficiary** had no deductible, send a DSS-8110 giving the **beneficiary** 10 workdays notice of the additional or new deductible amount.
 - (1) Allow the **beneficiary** the opportunity to provide any additional medical expenses to meet the deductible.
 - (2) If the **beneficiary** meets the additional deductible, there is no overpayment.
 - (3) If there is an unmet deductible, request a Medicaid/NCHC **Beneficiary** Profile for the period of ineligibility.
 - (4) For a MAF-C/N or MAD-C/N **beneficiary** found eligible for FPP coverage, subtract out all Family Planning services from the total claims paid to determine the total amount of expenses paid.
 - (5) Compare the amount of the unmet deductible to the amount of expenses paid by Medicaid during the period of ineligibility. The overpayment is the lesser of the two amounts.

5. Income Example:

1/17/18: A 30-year-old applicant applied for Medicaid for herself and eight-year-old. She reported being on medical leave from Little Tikes since 12/10 due to an injury she sustained at home. She provided a letter from her employer verifying she was on medical leave and her last pay received 12/15. No other pay was expected. She indicated she did not know how long she would be on medical leave but has been assured she can return to work once she's cleared by the doctor. She states no one pregnant or disabled. A/B stated she files taxes and expects to claim her child. She states no unpaid medical bills for household members, and no bank accounts.

01/23/18: Application approved for MAF-C from 1/1 – 12/31 for applicant her and her child. A/B instructed by CW to report all changes within 10 days.

11/25/18: An Exparte review was completed. During OVS/OLV computer checks, CW noticed wages for 1st quarter 2018 for Little Tikes. These wages were not reported. Based on the information, the case is ineligible for MAF-C. She is eligible for MAF-D. A DSS-8110 was sent by the IMC to notify the beneficiary she will begin receiving MAF-D effective 1/1. A referral was sent to the PI unit for a possible overpayment.

02/12/19: The employer verified that the beneficiary started back to work part-time 2/15. It was also verified that she is paid \$450 on the 15th and 30th.

If the beneficiary had reported her return to work timely, she would have had a deductible, effective 3/1. Beneficiary is also ineligible for Transitional Medicaid. Prior to returning to work she had not received Medicaid in three of the six months immediately preceding the first month of ineligibility. Since the countable income exceeds the CN income limit of \$472, eligibility must be evaluated for the MN with a deductible.

Beneficiary is ineligible for MAF-C benefits received in April - December. The deductible would have been effective March 1st due to timely notice requirements. A DSS-8110 was sent by the Investigator requesting unpaid medical bills that could meet the deductible. During the interview, **Beneficiary** stated she had no unpaid medical bills to meet a deductible. Beneficiary did not respond to request for additional information.

Calculate the overpayment using the following steps:

Rule: Determine the beginning point of period(s) of ineligibility

Change due: 2/15

10 Calendar days to report: 2/25

10 workdays for notice (being the day after 10th report date): 3/13

First month of deductible: March

First month of ineligibility: April

Rule: Calculate budgets for each certification period separately using the verified base period income. See Family and Children's Manual sections: [MA-3305 MAF, MIC, HSF Budgeting](#) and [MA-3306 Modified Adjusted Gross Income \(MAGI\)](#).

Rule: Compare new budgeted income to the appropriate income levels for the period to determine eligibility.

Rule: If the new income exceeds the income level, determine the deductible.

Rule: Send a [DSS-8110](#) to notify the **beneficiary** of the new or revised deductible, allowing the **beneficiary** time to provide unpaid medical bills to meet the deductible.

Rule: Request a Medicaid **Beneficiary** Profile ([DHB-7063](#)) for the authorized overpayment period.

Rule: Compare the amount paid by Medicaid to the amount of the unmet deductible.

Calculating the Deductible:

March 2018 – June 2018

Countable Monthly Income
\$900.00 – \$68.58 = \$831.42

Or

\$ 450 x 2 = \$900.00
\$ 900.00 Monthly income
\$ -90.00 Work Expense
\$ 810.00 Countable Income

Income Exceeds C/N Income Limit
of \$569.00

\$ 810.00 Countable Monthly Income
\$ - 317.00 MN Maintenance
\$ 493.00 Excess Income
 X4 March – June 2018
\$ 1,972.00 Deductible

July 2018 – December 2018

Countable Monthly Income
\$900.00 – \$68.58 = \$831.42

Or

\$ 450 x 2 = \$900.00
\$ 900.00 Monthly income
\$ -90.00 Work Expense
\$ 810.00 Countable Income

Income Exceeds C/N Income Limit
of \$569.00

\$ 810.00 Countable Monthly Income
\$ - 317.00 MN Maintenance
\$ 493.00 Excess Income
 X6 July – December 2018
\$ 2,958.00 Deductible

The deductible for 3/2018 through 6/18 is \$1,972.00

The deductible for 7/18 – 12/18 is \$2,58.00

Rule: Determine the amount of claims paid by Medicaid during the period of ineligibility.

Rule: If the **beneficiary** received MAF-C or MAF-N and is eligible for FPP, subtract out the FPP services from the total claims paid.

A Medicaid/NCHC Beneficiary Profile was ordered for the period of ineligibility, 04/18 through 12/18. The total expenses paid by Medicaid were:

04/18 – 06/18 = \$ 1,500.00 with no FPP services.

04/18 – 06/18 = \$ 1,500.00 in total claims

07/18 – 12/18 = \$ 1,200.00 with \$400.00 in FPP services.

07/18 - 12/18 = \$ 1,200.00 - \$400.00 = \$800.00 in total claims.

Rule: Compare the amount paid by Medicaid to the amount of the unmet deductible. The amount of the actual overpayment is the lesser of the two amounts.

The deductible for March – June is \$1,972.00. The total Medicaid claims paid during this period is \$1,500.00. The claims amount for this period is the lesser of the two; therefore, **\$1,500 is the overpayment for April – June.**

The deductible for July – December is \$2,958.00. The total Medicaid claims paid during this period is \$800.00. The overpayment amount for this period is the lesser of the two; therefore, **\$800.00 is the overpayment for July - December.**

The total overpayment in this case is each period.

\$ 1,500.00 (January - June) + \$ 800.00 (July – December) = \$2,300.00.

6. If ineligibility is the result of a **beneficiary** error in determining the amount of expenditures for medical care applied to the deductible, the amount of the overpayment is the lesser of:
 - a. The amount of Medicaid payments made on behalf of the **beneficiary**, or
 - b. The difference in the actual amount of incurred expenses and the amount of the deductible.

Example: The deductible for May-October is \$865. Based on the medical charges provided, the **beneficiary** was authorized effective June 2. It is later discovered that a \$115 charge that had been applied to the deductible was incorrectly applied. (The **beneficiary** forged her name on the bill, but it was in fact for services rendered to an individual not in the b.u.) The profile shows that \$1055 was paid for medical charges during the c.p. Subtract the actual amount of incurred expenses that could be applied to the deductible (\$750) from the deductible amount (\$865), and compare this amount (\$115) to the claims paid (\$1055). The lesser amount (\$115) is the overpayment amount.

This is applicable only if the error was on the part of the **beneficiary**. If the **local agency** makes an error in applying expenses to the deductible, it is an agency error and cannot be recouped from the **beneficiary**. Therefore, no claim should be entered in **NC FAST**.

C. Overpayment Methodology for Excess Resources

1. Determine the period(s) in which the **beneficiary** was ineligible due to resources that exceeded the reserve limit.
 - a. The period of ineligibility may encompass a **whole or partial** c.p., several contiguous c.p.'s, or in the case of reserve fluctuating above and below allowable limits, there may be non-contiguous periods of ineligibility.

Modified Adjusted Gross Income (MAGI) methodology became effective 4/1/2018. MAGI do not have Resource limits, only MAF-M groups in F&CH MA.
 - b. In determining the point of beginning ineligibility, allow adequate time for changes to have been reported and for appropriate action to have been taken by the local agency.
2. Determine excess reserve for each separate period of ineligibility.
 - a. Verify all resources available to the **beneficiary** during each period of ineligibility.

- b. Determine the dollar amount by which reserve most exceeded allowable limits during each period in question.
 - (1) Verify the reserve amount for each month.
 - (2) Compare the reserve for every month during the period of ineligibility. Use the largest amount in the overpayment calculation.
 - c. Notify the **beneficiary** on the DSS-8110 of the amount of excess reserve in each period of ineligibility and request verification, if any, of reduction of reserve.
3. Determine the amount paid by Medicaid during each separate period of ineligibility.
- a. Request a Medicaid/NCHC **Beneficiary** Profile via the DMA-7063 from **DHB** Office of Compliance and Program Integrity.

Do not combine requests for NCHC and Medicaid claims on the same DMA 7063.
 - b. If there is more than one period of ineligibility, request a Medicaid/NCHC **Beneficiary** Profile for each separate period of ineligibility under the heading entitled "Dates of Service." See MA 3535, XVIII. for complete instructions on requesting Medicaid/NCHC **Beneficiary** Profiles.
4. Determine the amount of the overpayment.
- a. Determine the overpayment for each period of ineligibility separately.
 - b. The amount of the overpayment for each period of ineligibility is either the amount paid by Medicaid during that period or the highest dollar amount by which reserve exceeded allowable limits, **whichever is less.**
 - c. If there is more than one period of ineligibility, add together the overpayments from each period to get the total amount of the overpayment.
 - e. If there are separate periods of ineligibility which are separated by gaps in authorization (not by periods of eligibility), there is only one overpayment based on either the maximum amount of excess resources for the periods or the amount paid by Medicaid for all the periods, whichever is less.

Example: A **beneficiary** authorized May-April is terminated at the end of the c.p. due to failure to return information. The **beneficiary** re-applies and is authorized January-December. At the review at the end of the latter c.p., it is discovered that the **beneficiary** unreported IRA Distributions that caused excess resources during both c.p.'s. The maximum excess resources for May-April were \$660 and for January-December were \$720. The total amount of claims paid for both periods was \$1,095. The overpayment amount is \$720 (the lesser of \$1,095 and \$720).

D. Evaluating Unreported Earned Income Cases

1. Evaluate ineligible MAF-C cases with unreported earned income for Job Bonus, Earned Income Disregard under Extended Medicaid for Working Families, Transitional Medicaid, and continuous eligibility for children under age 19 before determining an overpayment.

The Earned Income Disregard under the Extended Medicaid for Working Families applies only to the period of 11/01/99-8/31/03. Job Bonus is no longer applicable after 1/2014.

2. Part of the eligibility evaluation for Medicaid includes assessing whether the **beneficiary** would have been eligible for Job Bonus, or Extended Medicaid for Working Families had the change in earned income been reported correctly and timely.
3. Refer to the MA-3400, Four Month Transitional, MA-3405, Twelve Month Transitional Medicaid, and MA-3410, Termination and Deletions, for procedures for determining whether these continuations apply.
 - a. First determine if a **beneficiary** under age 19 is entitled to continuous eligibility for the remainder of the certification period.
 - b. Next evaluate first to see if the **beneficiary** would have been eligible for the Job Bonus. If eligible for the Job Bonus subtract those months from the ineligible period.
 - c. Once the Job Bonus months have been exhausted, evaluate for 12 months Earned Income Disregard under Extended Medicaid for Working Family. Subtract those months from the ineligibility period.
 - d. Once the 12 months of Earned Income Disregard has expired apply Transitional Medicaid guidelines to any remaining ineligible months.
 - e. If 12 months transitional Medicaid does not apply, evaluate next for the 4 months Transitional Benefits.
 - f. If the 4 months Transitional Benefits does not apply, evaluate for the one-month Transitional Benefits.
4. If any of the extensions apply, medical expenses for those months would not be part of an overpayment as the **beneficiaries** would have been Medicaid eligible. If there is a period of ineligibility, any benefits paid by Medicaid during those months would be part of an overpayment.

F. Evaluating MAF-N and MAF-M Cases

If a **beneficiary** is found ineligible for Medicaid under one coverage group, apply the following principles to determine if a Medicaid overpayment exists.

1. Evaluate each **beneficiary** in the Medicaid case to determine if the beneficiary would be eligible under any other Medicaid coverage group. It is possible that some **beneficiaries** in the Medicaid case will have a Medicaid overpayment and some will not.

2. If this evaluation for eligibility indicates that all members of the case would have been ineligible for Medicaid under any coverage group, all payments made by Medicaid during the period of ineligibility are erroneous and should be considered an overpayment.

Example: Ms. Penny and her daughter, Hetty age 19 were authorized for MAF-M 7/01 after meeting a deductible using old bills. She is separated from her husband and receives alimony and works part-time. She has a deductible of \$1,098 for 7/1 - 12/31 that she met on 7/1 with an old bill of \$1,300.

In 11/18, the **local agency** learns that Ms. Penny's husband returned to the home on 9/5 and is employed. Due to his countable monthly income of \$850.00 the family has an increased deductible. The MAF-M case is terminated 11/30 as the client states she cannot meet the increased deductible.

Neither Ms. Penny nor Hetty are eligible under any coverage group. Since they cannot meet the new MAF-M deductible, any claims paid for them between 10/1 and 12/31 are an overpayment if less than the additional deductible.

Mrs. Penny and Hetty are not eligible for Transitional Medicaid due to the MAF-M classification.

G. Medicaid Transportation Overpayments

Medical transportation overpayments occur when a **beneficiary** and/or provider of transportation requests transportation reimbursement for visits they never made to the medical provider as claimed. To determine the overpayment for a Medicaid transportation claim, the investigator will need to take the following steps:

1. View **local agency** cases for the dates on which the **beneficiary** claimed a need for reimbursement for transportation and reimbursement was given, either to the **beneficiary**, or the provider of transportation services.
2. Request a Medicaid/NCHC **Beneficiary** Profile for the dates of service in question. Compare the providers who billed Medicaid to the transportation reimbursement logs.
3. It may be necessary to contact the medical provider if there is no Medicaid claim on file as providers have at least 12 months from the date of service to file claims.
4. The overpayment will be the amount reimbursed the **beneficiary** and/or provider of transportation services for any dates medical services were not rendered to the **beneficiary**.
5. Enter the claim in **NC FAST** using the Product Delivery Case number and program code the **beneficiary** was receiving at the time the overpayment occurred. **The Medicaid service Code will be 71.**

6. Depending on the circumstances, the debtor may be the **beneficiary**, the provider of transportation, or both.

IX. NORTH CAROLINA HEALTH CHOICE OVERPAYMENTS

- A. Establishing the periods of ineligibility for North Carolina Health Choice (NCHC) is based on the same policies and guidelines that are used to establish the overpayment periods for Medicaid cases.
 1. Allow time for advance notice requirements for changes that must be reported to the county, such as acquisition of comprehensive health insurance and moving out of state. The guidelines can be found in [MA-3255](#) NC Health Choice Carolina Health Choice.
 2. To determine when the **beneficiary** was notified of the major health insurance coverage it may be necessary to contact the health insurance provider, child support, the policyholder or the policyholder's employer.
 3. If it is determined that the insurance information was reported to the agency, this includes child support, the overpayment cannot be collected from the **beneficiary's** family. Agency responsible errors are not collectible and should never be entered into **NC FAST**.

B. Calculating NCHC overpayments occurring on or after July 1, 2010

Effective July 1, 2010, the Division of Medical Assistance eliminated the premium payments for NCHC. Overpayments for NCHC is based on the amount of claims paid during the period of ineligibility.

1. When establishing NCHC **beneficiary** overpayment amount for potential fraud, there is no separate evaluation for Medicaid eligibility.
2. Do not establish an overpayment for the enrollment fee on a **beneficiary** who was authorized under MIC-J but should have been authorized as MIC-K.
3. Determine the amount paid by NCHC during the period of ineligibility:

Request a Medicaid/NCHC **Beneficiary** profile via the DMA-7063 from **DHB** Quality Assurance.

Do not combine requests for NCHC and Medicaid claims on the same [DHB-7063](#).

EXAMPLE:

01/02/2018: Ima Lyon applies for Medicaid for her 8-year-old grandson, Tommy Thumb. She states her son, Thom Thumb, left his son in her care when he took an out of state assignment. She states the only income Tommy has is from Social Security (due to his mother being deceased) in the amount of \$1,400/month. She states she receives no child support.

01/20/2018: Tommy Thumb approved for NCHC from January 2018-December 2018.

11/30/2018: An Exparte review was completed by the caseworker. There were no reported by household, case recertified for NCHC January 2019-December 2019.

10/15/2019: The **DHB PI Beneficiary Fraud Consultant** received a call from Pretty Madd, ex-girlfriend of Thom Thumb. She stated she just learned his son was getting Medicaid. She stated she wanted to know how this could be since his father is in the home and working. She reported that he works for “On the Move Movers”, making \$2,500/month. She knows this is true because she does the books for On the Move Movers. Additionally, he has Tommy on his health insurance. She states Thom went to live with his mother Ima Lyon and Tommy on November 25, 2018 when she kicked him out. She faxed DHB proof of the insurance and his pay. A referral was sent to the **local agency’s** PI office.

01/06/2020: An investigation was conducted, and it was determined that Thom Thumb was in the home and had been at the time of Ms. Lyons’ last review. The verification obtained reflected that Mr. Thumb’s salary with “On the Move Movers” was \$2,500/month since he was employed as of 10/17/17. It also showed he paid for insurance for him and Tommy. The coverage with BCBS began 12/01/18. It was also determined that Mr. Thumb was not aware his mother was receiving NC Health Choice for his son.

Calculate the overpayment using the following rules:

Rule: Evaluate eligibility for all other coverage groups for each AU member.

Rule: Determine the unreported countable income during the certification period(s).

Rule: Re-compute the budget using the actual verified unreported income received during the overpayment base period. If there are multiple certification periods, re-compute budgets for each period separately.

Tommy was eligible for NCHC from January - December.

His father, Thom Thumb moved in with him and Ima Lyon on 11/25/2018. Ms. Lyon should have reported the change in household composition within ten days. When Thom’s income is added together with Tommy’s SSA income, Tommy is ineligible for NCHC effective with January 2019.

The period of ineligible is from January 2019- December 2019

Rule: Determine the overpayment amount.

The overpayment for January -December is based on the actual services used. To determine this amount, a profile (DMA-7063) must be sent to **DHB**.

The profile is ordered, and it shows that \$4,596.35 in services was used during January – December.

Rule: Calculate the total overpayment.

The total overpayment is based on the actual NCHC claims paid (January 2019-December 2019), which is \$ **4,596.35**.

X. CONCLUSIONS AND RECOMMENDATIONS

A. Case Evaluation

The purpose of a full case evaluation is to review and organize all the data gathered during the investigation to compare that data to all relevant regulations, policies and laws, and to weigh and prioritize the results. This leads to a decision as to the action to be taken on the case.

The **local agency** must use specific standards for prioritizing cases and apply them in the same way to all cases to ensure that individuals are treated equitably. The standards are set by the **agency** in consultation with its local legal advisor. Consistency in application of these standards is imperative.

B. Responsibility of Overpayment

1. The PI investigator/caseworker must determine whether an existing overpayment is the result of suspected fraud, client error or agency error.
2. If the overpayment was the result of an agency error take immediate action to correct current eligibility. An overpayment that is the result of agency error cannot be collected from the **beneficiary**.
3. If a client error occurred, take immediate action to correct ongoing eligibility and refer the case to the agency's PI unit for investigation.
4. If fraud or misrepresentation is suspected, refer the case to the agency's PI unit for investigation, making sure to give all information obtained to date.

If the case remains the responsibility of the caseworker to determine fraud/abuse, the caseworker must follow all the steps outlined in this section and report the results.

C. Determining Who the Debtor Is

1. Debtors may include financially responsible adults, including parents of children, adult **beneficiaries** and legal spouses of **beneficiaries**, if they failed to report income and/or assets of any kind, or joined in the process of intentionally misrepresenting eligibility factors.
 - a. Debtors may also be non-**beneficiaries**, such as the applicant's representative, if they fail to report income and/or assets of the **beneficiary**.

- b. Other non-beneficiaries may also be debtors if they use another beneficiary's Medicaid card to obtain benefits.
- c. If the beneficiary "loaned" the Medicaid card to the non-beneficiary, they are co-debtors in the overpayment claim.

Example: The beneficiary may be a victim of theft. If someone steals a beneficiary's Medicaid card and uses it to obtain Medicaid benefits, then the non-beneficiary is considered the debtor. In this case the beneficiary would not be included as a debtor. However, if there is proof that the beneficiary loaned the card to the non-beneficiary, then he is a co-debtor in the overpayment claim with the non-beneficiary.

- 2. Under no circumstances would an individual who received benefits as a dependent child under age 18 be considered a debtor, even after the individual reaches age 18.
 - a. Determine how old the beneficiary was at the time of the overpayment and who the financially responsible adult(s) was during the overpayment period.
 - b. If a beneficiary is determined to be incompetent, he/she may not be considered a debtor. However, an overpayment can still exist. In this case, the representative, often the Power of Attorney (POA), may be found to be the debtor as the POA may be the person who benefited by the fraud/misrepresentation. **Each situation should be evaluated based on its own merit.**
- 3. Beneficiaries age 18-21 who is receiving as a child:
 - a. Can never be a debtor.
 - b. Can be a debtor if he is receiving as an individual under age 21 living financially independent of his parents. (MA-3305, III., Financial Responsibility.)
- 4. Below are examples of who would be considered financially responsible in certain cases:
 - a. MAF individual living financially independent of the parent: If the parent(s) of the "child" aged 18-21 conspired to assist the "child" in obtaining benefits, by falsely claiming the child was financially independent, and the parent's income and/or resources made the "child" ineligible, then the adult child and the parent(s) are both debtors. If the parent was unaware of the situation, then the beneficiary receiving Medicaid under the false pretense of being financially independent of his parents will be the only debtor.
 - b. MAF individual 18-21 still living in the home of his parent(s) or caretaker: If the parent/caretaker applies for the "child" they are considered financially responsible, and if there is misrepresentation, the parent/caretaker is the debtor.
 - c. MIC: When both parents are in the home and either applies for their children, both would be debtors. If the 18-year-old applies for himself, and does not live with his parents, he is financially responsible for himself and could be the debtor.

However, if the child lives with a single parent, the parent who makes the application is the debtor.

- d. **NCHC**: When both parents are in the home, both would be debtors. However, if the child lives with a single parent, the parent who makes the application is the debtor.

D. Guidelines for creating claims in NC FAST when the case head is not the debtor or is not the only debtor.

1. Create the claim in **NC FAST** in the case head's name, since the claim must be tied to the correct **Product Delivery Case** or Case ID (legacy EIS cases only) and authorization period(s) for the **Medicaid** program.
2. If the debtor non-**beneficiary** debtor does not have an CNDS ID, create one in **NC FAST** using the instructions in the **Job Aid, Registering Persons**. Once the CNDS ID has been created, add the debtor to the PLC.

E. Combining Legacy EIS Cases on a PLC in NC FAST

1. A legacy EIS case may have more than one Medicaid overpayment. Combine multiple overpayment periods for a case into one claim in NC FAST as long as the overpayment periods are within the same Medicaid program category (i.e., MAF, MIC, MPW) **unless one of the overpayment periods is based on a court order and the other is not**.
2. Use the case ID for the most recent overpayment period. Enter each overpayment period in the overpayment field on the claim detail screen. Refer to the **job aid, PI-Establish a Claim/Product Liability Case**.
3. Do not combine NCHC or the Breast and Cervical Cancer coverage with any other Medicaid overpayments in **NC FAST**. Establish a separate claim for each program in **NC FAST** since each program has a separate funding source.

F. Investigative Summary

1. Complete the [DHB-7058](#), Investigative Summary upon completion of an investigation detailing all factors causing the overpayment, the overpayment period, and amount of the overpayment. **Attach a copy to the Investigative Case (unsubstantiated cases) or the Claim (substantiated cases) in NC FAST**.
2. The summary should contain recommended action based upon the investigator's knowledge of the situation. Weigh the merits of the alternatives for that case to determine the case objectives.
3. The overall objectives for any fraud investigation are punishment, restitution, deterrence, and the protection of society.
4. Present the completed summary to the Local Agency's Board of Social Services or its designee for a decision on whether to refer for prosecution, or to use administrative procedures for collection. Follow your local agency's procedures.

5. All available options must be utilized to attempt collection on any debt owed to **DHB**.

G. Referral to **Local Agency Board of Social Services**

1. The Agency's Board of Social Services or their designee is responsible for the review of the case circumstances and the final decision on whether to recommend referral for prosecution in accordance with state statutes.
2. The following factors must be given consideration:
 - a. Was there a violation of policy?
 - b. Was the violation of policy against the law?
 - c. Were the elements of criminal action present?
 - d. Did a **beneficiary** willfully and knowingly, with intent to deceive:
 - (1) Make a false statement or representation,
 - (2) Fail to disclose a material fact,
 - (3) And as a result, obtain, attempt to obtain or continued to receive Medicaid for himself or others?
 - e. Mitigating factors
 - (1) Prior/repeat offenses
 - (2) **Beneficiary's** physical and/or mental state
 - (3) Recommendation of County District Attorney
 - (4) Any other factors pertinent to the case (such as the Statutes of Limitations)

H. Guidelines for Criminal Prosecution

If the **Local Agency** Board of Social Services determines that a case should be referred for prosecution, there are several actions that will help ensure the case is disposed of justly.

1. Relationship with the Prosecuting Attorney
 - a. The **agency** should establish a good working relationship with the District Attorney or County Attorney, whichever handles prosecution of fraud cases. The worker responsible for the case should ensure the attorney understands program requirements as they relate to the case. All case documentation should be provided to the attorney along with the investigative summary. The worker should be available to answer any questions that the attorney may have about any specific

case or about program policies, procedures and regulations. Do not schedule court proceedings until all documentation is in hand.

- b. The **local agency** should expect advice from the **agency's** attorney on whether a case has enough evidence for prosecution, whether further evidence is required, and the type of information the attorney considers necessary for successful prosecution.
- c. The attorney should be expected to help the agency in such areas as issuing warrants, appearing as a witness in court, etc.
- d. Representatives from the agency should meet with the attorney to discuss such a relationship. Only by discussing expectations will a worthwhile effort towards prosecution evolve.

2. Relationship with the Courts

- a. Take any opportunity that presents itself to speak with the judge who presides over prosecution of fraud cases in your county. Do not presume the judge needs to be educated in this area but use the opportunity to introduce those people who will regularly appear in the court in the cases.
- b. While you cannot presume to tell the judge, what sentence you wish rendered, you can inform the judge of certain program situations that may affect the sentence.
 - (1) An example is the fact that providers have 12 months in which to file claims and the warrant may not reflect the total amount of the overpayment.
 - (2) Another example is that CMS (the Center for Medicare and Medicaid Services) regulations do not allow for the compromise of Medicaid overpayment amounts.
- c. The judge may be able to advise you how to handle such situations. This does not suggest that you should meet with the judge or attempt to educate him on the law or influence his judgment in any way.

3. Relationship with Law Enforcement

- a. It is important to maintain a good relationship with the law enforcement branch that serves warrants in cases that have been referred for prosecution.
- b. Provide them with clear directions to the **beneficiary's** home, hours the **beneficiary** may be home and any other information that might expedite the serving of the warrant.

4. Appearing in Court

- a. When appearing in court in a possible fraud case, know the case thoroughly before taking the stand to testify. If you do not know the answer to a question,
 - b.

state you do not know. However, if the answer can be found in the record, state this fact and look in the record.

- c. Only testimony from the record should be given to avoid violating confidentiality and to avoid giving opinions. For this reason, the Case Summary should be a complete history of the investigation and should include all documentary evidence. Do not give opinions. If you have fully developed your case, everything you need will be contained in the investigative summary.
- d. Answer all questions as concisely as possible. If you must organize your thoughts before answering a question, do so. Do not rush into an answer that is not carefully thought out to avoid giving unnecessary or confusing information.
- d. Remember the following:
 - (1) Prepare and present the evidence as a professional; do not get personally involved in a case.
 - (2) Always dress neatly and be well groomed.
 - (3) Never chew gum; avoid nervous habits. Assume a comfortable position.
 - (4) Be on time.
 - (5) Always be completely honest. Speak clearly, slowly and loudly enough to be heard.
 - (6) Address the judge as "Your Honor" in the courtroom. "Judge" is proper outside the courtroom.
 - (7) If a court official addresses you when you are not in the witness stand, it is proper to stand before answering.
 - (8) Stop your testimony immediately when there is an objection. Do not resume until the objection has been ruled on and you are instructed to continue or answer another question.
 - (9) If you need witnesses or materials to prove your case, be sure they are available.
 - (10) Call your witnesses the day before the court date to remind them of the time and place of the trial.
 - (11) If you are disappointed with the disposition of the case, do not let it show in court.

XI. NOTICES & APPEALS

A. Notices

When a claim is established in **NC FAST** the following occurs:

1. The [DHB-8010/8010S](#), Notice of Overpayment for Medical Assistance, is generated for each debtor on the claim. The notice contains the initial overpayment amount and the period of ineligibility. **The notice is produced based on the individual's language preference located on the Person Page>Evidence Tab.**
 - a. The initial overpayment amount may change if additional claims are paid for medical expenses that were incurred during the period of ineligibility. The [DHB-7059](#), Notice of Change in Overpayment for Medical Assistance, notifying each debtor of the change in the overpayment must be **manually** sent.
 - b. **Attach a copy of the manual [DHB-7058](#) to the PLC.**
2. The notice is mailed the next business day after the claim is established. The date the notice is mailed is the date on the Letter of Overissuance (LOI) field.
3. The [DHB-8010](#) is mailed to the mailing address listed in **NC FAST** for each debtor.
 - a. If an incorrect address is listed for the debtor on the Debtor Detail screen, **NC FAST** will send the [DHB-8010](#) to the **local agency** address responsible for the referral.
 - b. When the [DHB-8010](#) is returned to the **agency** with no forwarding address, the Program Integrity Unit is responsible for searching all available resources for a mailing address and forwarding the notice to the debtor.
 - c. If an address is located:
 - (1) Update the notice mailing date, the mailing address, and the 60-day hearing date on the [DHB-8010](#).
 - (2) Forward the notice to the new address. File a copy of the revised notice in the case record and document the change.
 - d. If no alternate address is located, file the [DHB-8010](#) and documentation of all sources searched for an address in the case record.
4. A report, **EPI433** Letter of Over issuance, is produced daily. The report lists all debtors who were mailed a Notice of Overpayment. The report contains:
 - a. The debtor's SSN and name
 - b. The Program Code

- c. **Claim overpayment amount**
 - d. **Investigative Case Reference number and PLC**
 - e. Date notice was mailed and the final hearing date (60th day)
5. The notice instructs the debtor to contact the **local agency's** Program Integrity Investigator to set up a voluntary repayment agreement if he has not previously made arrangements for full repayment of the debt.

B. Appeals

A **beneficiary** has the right to an appeal when benefits are modified or terminated. In the case of fraud/misinterpretation, the **beneficiary** may request an appeal of the corrected eligibility determination made during the investigation.

1. If a timely notice is sent and the client requests a hearing within the notice period, he may elect to continue to receive benefits until a decision is rendered from the initial hearing. See [MA-3430 Notice and Hearings Process](#).
2. If the initial hearing decision upholds the **local agency's** action, any benefits received by the **beneficiary** during the continuation of benefits period may be recovered by the state. The amount overpaid during this time should be added to any other verified overpayment when keying client responsible overpayments into **NC FAST**.
3. The automated [DHB-8010](#) "Notice of Overpayment for Medical Assistance" gives debtors 60 days to appeal the decision, or 90 days if they can show good cause for the delay. Follow the guidelines in [MA-3430](#) for the Hearings process.
4. If a debtor requests an appeal of the overpayment within the 60-day appeal period, or 90 day period with good cause (Refer to [MA-3430](#) for good cause definition):
 - a. Send a request to **the DHB PI Beneficiary Fraud Consultant to set the NC Debt Setoff indicator to "Hearing" in NC FAST**. This indicates there is a pending hearing and will prevent a NC Tax Intercept until the hearing has been held, and a decision has been made.
 - b. Contact the agency's **DHB PI Beneficiary Fraud Consultant** to remove or change the indicator upon receiving the final hearing decision.

XII. ADMINISTRATIVE COLLECTION PROCEDURES

If the **Local Agency's** Board or its designee chooses not to refer the case for prosecution, the following options are available:

A. Voluntary Repayment Agreement

1. The debtor must indicate willingness to repay and will be given the opportunity to repay the overpayment in a lump sum payment or a specified amount on a monthly basis. Use the [DHB-7060, Voluntary Repayment Agreement \(VRA\)](#).
 - a. **Negotiate full repayment between 36 - 60 months. Extensions over 60 months must be approved by DHB OPCI.**

b. If a debtor is unable to repay the overpayment within 60 months, a hardship request must be faxed on county letterhead to the agency's assigned DHB PI Beneficiary Fraud Consultant at (919) 800-3186 with the following:

- (1) Product Delivery Case
- (2) The proposed payment and number of months it will take to Repay the overpayment
- (3) Reason for the hardship
- (4) Signatures of the PI staff completing request and PI Supervisor

Do not execute the VRA with the debtor until a response has been received from the DHB PI Beneficiary Fraud Consultant.

2. Always have the VRA notarized and keep a copy in the file. Send copies to Medicaid and WF for their files.
3. When a debtor fails to make the first payment of a VRA send a reminder letter. If a payment is not received within 30 days, take action to establish personal and/or telephone contact with the individual.
 - a. If the debtor continues to refuse to repay, consider small claims court, civil court action or the set-off debt collection process.
 - b. In the case of the death of a debtor with an outstanding debt, the **local agency** must file a claim against the deceased's estate for restitution.
 - c. If the word "Seal" appears next to the debtor's signature, this will guarantee the investigator a longer period of collection. The civil statute of limitations for enforcement of collection is ten years from the date the VRA was signed. However, make sure the word "Seal" has been circled by the debtor. If further information is needed, contact your agency's attorney.

B. Voluntary Wage Withholding

1. Complete the [DHB-7061](#), Voluntary Wage Withholding Agreement. Ensure that the wage withholding form has the word "Voluntary" on it and that all copies are notarized. Copies of the voluntary wage withholding form should be distributed as follows:
 - a. Send the employer a copy via certified mail.
 - b. Give the debtor a copy.
 - c. Attach a copy to the **NC FAST Product Liability Case (PLC)**.
 - d. Send copies to Medicaid, and WF and FNS for their files.

Always have the debtor sign a VRA as well as the Voluntary Wage Withholding agreement. Then, if the debtor quits a job, even though the voluntary wage withholding form is no longer valid, the agency still has the VRA.

C. Civil Court

1. Civil Court procedures are used solely for repayment. If the **beneficiary** is found liable, the court may enter a judgment against the **beneficiary** for the amount owed to the **agency**. Civil Court procedures may also be used when a **beneficiary** has failed to uphold a previously signed Voluntary Repayment Agreement. Consider the following factors:
 - a. Proof of the overpayment amount
 - b. Failure to repay the overpayment if a Voluntary Agreement was previously executed
 - c. Court costs
 - d. The likelihood of satisfying a judgment against the **beneficiary** given the allowable exemptions
2. Information is available through each county Clerk of Court on procedures to follow for this type of action. It is recommended that this source be used. Civil Court procedures should also be initiated in cases in which criminal prosecution failed to yield restitution in full for overpayments.

Example: A **beneficiary** found guilty of felonious fraudulent misrepresentation by the Superior Court is ordered to pay \$1,385, is given a suspended sentence of four years in prison and is placed on four years' probation. Payments received during the probationary period did not repay the entire amount owed and contact by the **agency** with the probation office produced no results.

When the order terminating probation was established, it was ordered that the arrearage be remitted. In this situation, civil action could be pursued to recover the amount owed. The **agency's** attorney may have to consult with the Attorney General's office, if needed.

D. Delinquent Accounts

Court Ordered Restitution - Upon notification of delinquent accounts, take the following actions:

1. **Probation Office:** For debtors who fail to comply with the terms of court ordered restitution and are on probation, contact the probation office to determine appropriate follow-up action, such as tax intercept or wage garnishment. If the debtors are complying with the court order obligation, make sure the debtor's taxes are not intercepted.
2. **Clerk of Court (COC):** For debtors who fail to comply with the terms of court ordered restitution and are not on probation, contact the Clerk of Court (COC) to determine appropriate follow-up action, such as tax intercept, wage garnishment or non-compliance order. In some cases, the COC may issue an order for arrest for non-compliance.

Investigators are encouraged to seek permission from the Clerk of Court to issue non-compliance orders.

E. Estate Recovery for Deceased Debtors

1. A Medicaid overpayment can be recovered from a deceased debtor's estate when a **beneficiary** owes **DHB** for claims paid by Medicaid on the decedent's behalf, but for which he was ineligible. This is separate from Third Party Recovery claims on LTC cases.
2. If an overpayment is involved for a deceased debtor, the **local agency** should collect the overpayment amount first, as the **agency** receives a greater incentive for overpayment collections, than for regular Third-Party Estate recovery.
3. It is very possible to discover the overpayment upon the death of the **beneficiary** through verification with the Clerk of Court regarding the existence of assets of which the **agency** was unaware. At the point the investigator verifies resources that created ineligibility for Medicaid a claim should be established in **NC FAST**.
4. Request a Medicaid Profile via the [DHB-7063](#) for the overpayment dates involved. Refer to section XVII, below, for instructions on how to determine the amount of ineligible claims that have been paid.
5. It is vital to complete the formal letter, "Notice and Presentation of Claim Against Estate." This letter must be completed and presented to the Clerk of Court and to the executor of the estate stating the amount of the overpayment. This establishes a claim against the estate on behalf of the **agency**. Contact your local county Clerk of Court to obtain the letter.

F. Wage Garnishment

1. General Overview

Wage Garnishment is a legal summons to withhold wages to satisfy a debt resulting from fraudulently receiving benefits from the Medicaid Program. North Carolina General Statute 108A.25.3 allows the garnishment of wages to recoup fraudulent public assistance benefits. This law applies to civil actions filed on or after December 1, 1997, regardless of the date the claim was established. A judge or jury in Criminal Court must determine the act of fraud.

The garnishment process cannot be initiated to collect delinquent NCHC overpayments.

2. Wage Garnishment Criteria:
 - a. The garnishment process cannot be initiated until all administrative collection methods are exhausted. The **agency** must attempt to establish a cash repayment agreement. If the individual fails to meet the terms of the agreement, garnishment proceedings cannot be initiated until the account is 60 days delinquent. If the debtor makes a payment after the garnishment process begins, the garnishment procedure will continue.

- b. Garnishment is not an option if a debtor is required to pay restitution for fraudulently receiving Medicaid benefits pursuant to a criminal court order. However, if the debtor does not pay in accordance with the court order a separate civil action can be filed. This needs to be coordinated with the probation officer.
- c. The garnishment cannot exceed 20% of the monthly disposable income. Disposable income is defined as net income (wages, salary, commission, bonus, or other), or that which remains after any legally withheld deductions are made. Legally withheld deductions are those deductions required and not an option. These include Federal and State taxes, as well as Social Security. Retirement is also a required deduction with some employment.
- d. A civil judgment must be obtained against the debtor prior to completing an order for garnishment. The amount due is the amount of the fraudulent benefits and any applicable court costs.
- e. The order for garnishment may be entered 10 calendar days after the judgment is filed with the Clerk of Court.
- f. An order for garnishment may not be entered if the court finds that the order jeopardizes the debtor's ability to become or remain financially self-sufficient, resulting in the likelihood of increased or recurring dependency on public assistance, or an inability to secure basic necessities.
- g. The investigator will need to complete necessary budgets to determine if the garnishment would jeopardize the debtor's ability to remain self-sufficient.
- h. Once the fraudulent benefits and the costs of court are paid in full, it is the responsibility of the agency to have the judgment removed at the Clerk of Court. The local agency must remove the judgment within 30 days of full repayment of the fraudulent benefits and costs of court.

Local agencies should obtain the North Carolina Rules of Civil Procedures from the Clerk of Court's Office if they do not already have one available.

3. Wage Garnishment Procedures

A judgment may be obtained after the civil court hearing is held or by default of the hearing. Default of the hearing occurs when the debtor fails to appear for the hearing or fails to make a plea regarding the matter. Once a judgment is entered, the **local agency** may petition the district court for an order of garnishment. The "Petition for Order of Garnishment", must include the following:

- a. Indication that the person is a former/current **beneficiary**.
- b. An explanation of which public assistance programs are involved.
- c. The amount of the fraudulent overpayment.
- d. Circumstances surrounding the fraudulent benefit, and why it is fraudulent.

- e. Information that all administrative means to collect the benefits have been exhausted unsuccessfully.
- f. Verification that **local agency** has obtained a judgment. A copy must be attached to the petition.
- g. The name and address of the garnishee.
- h. The debtor's verified monthly disposable income. Attempt to verify this through the employer or client. If this is not available, use the **Division of Employment Security (DES)** information as last resort.
- i. Verification that the proposed garnishment does not exceed 20% of the debtor's monthly disposable income.
- j. The Petition for an Order of Garnishment must be served on the debtor, and on the garnishee usually the current employer of the debtor.

4. Instructions for Completing Petition for Order of Garnishment

Contact your local Clerk of Court Office to obtain the “Petition for Order of Garnishment”. Instructions are listed according to paragraph numbers in the Petition.

- a. The petition may be brought by the **agency**.
- b. A district court judge in the county where the debtor resides or is found, or in the county where the overpayment occurred may enter an Order for Garnishment. One of these situations must be alleged in the petition.
- c. Orders for Garnishment may be obtained against debtors of public assistance. The petition must allege that the defendant is a past or current **beneficiary**. The allegation should explain what program of public assistance is involved (for these purposes, Medicaid).
- d. The petition must allege the amount of the fraudulent benefit(s).
- e. The petition must provide the court with facts and circumstances surrounding the fraudulent benefit. The petition must allege how the benefit(s) is fraudulent.
- f. The **agency** is required to exhaust all administrative remedies prior to pursuing garnishment. The petition should state that all administrative means have been exhausted unsuccessfully.
- g. The petition must indicate that the **agency** has obtained a judgment for a certain sum against the individual. A copy of the judgment should be attached to the petition.

- h. The Garnishee must be identified, and the garnishee's address must be given.
- i. The petition must give the debtor's monthly disposable income.
- j. No more than twenty percent (20%) of the debtor's monthly disposable income can be withheld. If the fraudulent benefit cannot be recovered in one payment, the petition must state the amount the **agency** wishes to be withheld from the debtor's monthly disposable income.

5. Time Restrictions for the Order of Garnishment

The service must be in accordance with Rule 4 of the North Carolina Rules of Civil Procedure, which states that upon the filing of the complaint, a summons shall be issued within 5 days.

- a. The summons shall run in the name of the State and be dated and signed by the Clerk, Assistant Clerk, or Deputy Clerk in the county in which the action is commenced.
- b. The complaint and summons shall be delivered to the sheriff of the county where service is to be made or to some other person duly authorized by law to serve summons.
- c. Service must be made within 30 days after the issuance of the summons and returned immediately to the issuing clerk who issued it with notation of service.
- d. The debtor and the garnishee have 30 days from the date of service to respond to the petition in accordance with Rule 12 of the Rules of Civil Procedure. A hearing date is set regarding the petition and is heard before a district court judge. Following the hearing the judge may or may not enter an Order for Garnishment.
- e. The Order for Garnishment may be entered in the county where the debtor resides, or is found, or in the county where the overpayment occurred.
- f. If an order is entered, a copy must be served on the debtor, as well as the garnishee. The order must be served personally or by certified mail, with return receipt requested.
- g. The order must include sufficient findings of facts to support the action by the court and the amount to be garnished each pay period.
- h. The amount to be garnished is based on the debtor's verified monthly disposable income. The amount garnished each pay period may be increased by an additional \$1.00, which is a processing fee, and retained by the garnishee (employer) for each payment under the order. The \$1.00 processing fee is the responsibility of the garnishee.
- i. The order shall be subject to review for modification and dissolution upon filing of a motion in the cause.

- j. A certified letter is also mailed to the garnishee advising him of his responsibilities regarding the Order of Garnishment.
- k. Upon receipt of the order of garnishment, the garnishee transmits without delay to the Clerk of Superior Court the amount ordered by the court to be garnished. The funds are disbursed to the **local agency** to recoup fraudulent benefits subject to the order of garnishment.
- l. A garnishee that violates the terms of an order of garnishment shall be subject to punishment for contempt.

H. Liens and Recoveries

The **agency** may place a lien against a debtor's property, both personal and real, because of claims paid or to be paid on behalf of that debtor following a court judgment which determined the benefits were incorrectly paid for that debtor.

XIII. BANKRUPTCY

A. General Overview

Generally, bankruptcy means that a person has become unable to repay his debts in a timely manner due to a lack of funds in the foreseeable future. The debtor is seeking relief from all or part of his debt. According to a Supreme Court decision in 1934 the purpose of the bankruptcy law:

“It gives the honest but unfortunate individual a new opportunity in life and a clear field for future effort, unhampered by the pressure and discouragement of preexisting debt.”

Bankruptcy Law is federal statutory law and can be found in Title 11 of the United States Code. Based on the U.S. Constitution, only Congress can regulate bankruptcy.

The individual States can only pass laws that govern other aspects of the debtor-creditor relationship. Since the federal government governs bankruptcy law, bankruptcy proceedings are supervised and litigated in the U.S. Bankruptcy courts, which are part of the District Court system of the United States. These proceedings are governed by the Bankruptcy Rules set by the U.S. Supreme Court under the authority of Congress.

There are different chapters under which a debtor or business may file for bankruptcy, with different rules governing each. The following information is meant as an overview for the Fraud Investigator. Please remember that each case is unique. The **local agency's** investigator must research each situation as it occurs. This is important in order to ensure the debtor pays as much of their debt to the **agency** (creditor), as the law will allow. Once you learn a debtor has filed for bankruptcy, it may be necessary to call on the county attorney or the agency attorney for advice on how to approach the Medicaid overpayment.

B. Notification

The first order of business should be that the **agency** is notified by the court that this debtor has filed for bankruptcy, and the **agency** has been named as a creditor from whom the debtor is seeking relief, either partially or fully, through the Bankruptcy court.

The agency may hear about the bankruptcy, but never receive official notification. This could happen if the debtor failed to list **the agency** as a creditor. In order to receive any distribution from the bankruptcy estate, the **agency** generally will need to file a proof of claim with the Bankruptcy Administrator. The necessity and advisability of filing a proof of claim may require evaluation by an attorney.

C. The 341 Meeting

At some point each creditor is notified of the “341 meeting”. Section 341 of the Bankruptcy Code requires a meeting be held at which the debtor(s) is questioned by the creditors. Depending upon the circumstances of the case, it might be advisable for a representative of the **agency** to attend this meeting. The **agency** may learn whether the debtor is seeking a full or partial discharge of the debt he owes. It is also a chance to hear what assets and disposable income this debtor is presenting to the court. The debtor is bound by law to be truthful, as concealing assets can lead to a dismissal of the Bankruptcy plan, if discovered at a later date.

D. How Bankruptcy Affects the Creditor

1. Bankruptcy is treated as a judgment and will stop most previous judgments. It also stops/prevents collectors/creditors from calling or contacting the party that filed the bankruptcy. Bankruptcy will be listed in credit reports for a period of up to 10 years.
2. If the court has already ordered restitution as part of a criminal conviction, this debt cannot be discharged through bankruptcy. The debtor will remain responsible for all of it. The **local agency** may continue to collect in every way as in the past.
3. Before the Bankruptcy Judge has confirmed a repayment plan, any creditor may object and seek full repayment according to certain specific exceptions to the bankruptcy discharge. There are time limits within which the objection must be made. This includes all creditors, even the **agency**. However, the Bankruptcy Judge makes the final decision.
4. Take a close look at your case and take any necessary steps to ensure the **agency** is not violating bankruptcy law. Once the **agency** has been notified, or becomes aware the debtor has filed for bankruptcy, they should stop collection efforts on all current claims. If a creditor continues efforts to collect, they could face a stiff fine by the court. This includes tax intercept. Contact your State **DHB PI Beneficiary Fraud Consultant** for assistance.
5. To prevent tax intercepts on a claim, send a request to **DHB PI Beneficiary Fraud Consultant** to add the **bankruptcy indicator in NC FAST**. This includes wage garnishment or wage withholding. Make sure to contact the employer to stop these actions.
6. If **local agency** establishes a new claim which arises AFTER a bankruptcy plan is already in effect, this new debt may not be governed by the Bankruptcy plan already in effect. It may be necessary to file an administrative claim in the bankruptcy proceeding in order to collect such debt, or it might be permissible to pursue

collection outside of the bankruptcy proceeding. The advice of counsel may be necessary to assist with this evaluation.

Exception: The debtor could request an Amendment to his Bankruptcy plan in order to add this new debt for discharge. Be aware that this could most likely happen in order to avoid tax intercept, or prosecution.

E. Types of Bankruptcy

Chapter 7: Entitled Liquidation. This is an orderly, court supervised procedure by which a trustee collects the assets of the debtor's estate, liquidates them, and distributes the proceeds to creditors. This is of course subject to certain rights of the debtor to retain exempt property and is also subject to the rights of secured creditors. Usually there are no assets in a Chapter 7. Also, under Chapter 7 a debtor can receive relief from dischargeable debts fairly quickly. He does not have to propose a repayment plan. For a creditor to receive anything from a Chapter 7 case, there needs to be assets, and the debtor must file a "proof of claim" with the bankruptcy court.

Chapter 9: Entitled Adjustment of Debts of a Municipality. This provides for reorganization just as Chapter 11 does, except it is only for municipalities, which includes cities, towns, villages, counties, taxing districts, municipal utilities, and school districts.

Chapter 11: Entitled Reorganization. This is usually used by commercial enterprises in order to continue operating a business while repaying creditors through a court-approved plan of reorganization.

Chapter 12: Entitled Adjustment of Debts of a Family Farmer with Regular Annual Income. The difference between this and chapter 13 is that it allows a family farmer to continue to operate his farm while the repayment plan is being carried out.

Chapter 13: Entitled Adjustment of Debts of an Individual with Regular Income. This is designed for those with regular source of income. It also may enable the debtor to keep a valuable asset such as a house. The debtor must propose a "plan" to repay his creditors over a period of time, usually three to five years, through a trustee. The plan must be based on the debtor's anticipated income. The majority of Bankruptcy filings for individuals and couples are done under Chapter 13.

F. Bankruptcy Terminology

Below you will find widely used terminology relating to Bankruptcy procedures. **Assume** –

An agreement to continue performing duties under a contract or lease.

Automatic Stay – An injunction that automatically stops lawsuits, foreclosure, garnishments, and all collection activity against the debtor the moment a bankruptcy petition is filed.

Bankruptcy Administrator – An officer of the judiciary serving in the judicial districts of Alabama and North Carolina who, like the United States trustee, is responsible for supervising the administration of bankruptcy cases, estates, and trustees, monitoring plans and disclosure statements, monitoring creditors’ committees, monitoring fee applications, and performing other statutory duties.

Bankruptcy Estate – All legal or equitable interests of the debtor in property at the time of the bankruptcy filing. (The estate includes all property in which the debtor has an interest, even if it is owned or held by another person.)

Bankruptcy Petition – A formal request for the protection of the federal bankruptcy laws. (There is an official form for bankruptcy petitions.)

Claim – A creditor’s assertion of a right to payment from a debtor or the debtor’s property.

Complaint – The first or initiatory document in a lawsuit that notifies the court and the defendant of the grounds claimed by the plaintiff for an award of money or other relief against the defendant.

Confirmation – Approval of a plan of reorganization by a bankruptcy judge.

Creditor – A person to whom or business to which the debtor owes money, or that claims to be owed money, by the debtor.

Debtor – A person who has filed a petition for relief under the bankruptcy laws.

Discharge – A release of a debtor from personal liability for certain dischargeable debts. (A discharge releases a debtor from personal liability for certain debts known as dischargeable debts (defined below) and prevents the creditors owed those debts from taking any action against the debtor or the debtor’s property to collect the debts. The discharge also prohibits creditors from communicating with the debtor regarding the debt, including telephone calls, letters, and personal contact.)

Equity – The value of a debtor’s interest in property that remains after liens and other creditors’ interests are considered.

Exempt Property – Property or value in property that a debtor is allowed to retain, free from the claims of creditors who do not have liens.

Fraudulent Transfer – A transfer of a debtor’s property made with intent to defraud creditors or for which the debtor receives less than the transferred property’s value.

Lien – A charge upon specific property designed to secure payment of a debt or performance of an obligation.

Liquidation – A sale of a debtor’s property with the proceeds to be used for the benefit of creditors.

Liquidated Claim – A creditor’s claim for a fixed amount of money.

Motion to Lift Automatic Stay – A request by a creditor to allow the creditor to take an action against a debtor or the debtor’s property that would otherwise be prohibited by the automatic stay.

Non-dischargeable Debt – A debt that cannot be eliminated in bankruptcy.

Priority – The Bankruptcy Code’s statutory ranking of unsecured claims that determines the order in which they will be paid if there is not enough money to pay all of them in full.

Proof of Claim – A written statement describing the reason a debtor owes a creditor money. (There is an official form for this purpose.)

Secured Creditor – An individual or business holding a claim against the debtor that is secured by a lien on property of the estate or is subject to a right of setoff.

Secured Debt – Debt backed by a mortgage, pledge of collateral, or other lien; debt for which the creditor has the right to pursue specific pledged property upon default.

Schedules – Lists submitted by the debtor along with the petition (or shortly thereafter) showing the debtor’s assets, liabilities, and other financial information. (There are official forms a debtor must use.)

Trustee – The representative of the bankruptcy who exercises statutory power, principally for the benefit of the unsecured creditors, under general supervision of the court and the direct supervision of the United States trustee or Bankruptcy Administrator.

Unscheduled Debt – A debt that should have been listed by a debtor in the schedules filed with the court but was not. (Depending on the circumstances, an unscheduled debt may or may not be discharged.)

XIV. DISTRIBUTION OF CASH REPAYMENT

- A.** State law requires that in cases involving overpayments in more than one program, collections must be distributed equitably. This should be followed unless the debtor asks that a payment be applied to a particular claim.
- B.** It is important that the investigator or collections clerk explain to the debtor that failure to distribute payments among all their claims could cause a claim to become delinquent. If a claim in **NC FAST** is delinquent, the debtor’s North Carolina tax refund will be intercepted and applied toward the overpayment claim in **NC FAST**.

XV. NC FAST REPORTING REQUIREMENTS

DHB, Office of Compliance and Program Integrity/Quality Assurance is responsible for the administration of the Medicaid **beneficiary** investigations conducted by the **local agencies**. To comply with state and federal reporting requirements, each **agency** is responsible for entering all client responsible overpayment claims into **NC FAST**. Refer to the **job aid, PI – Establish a Claim/Product Liability Case** for instructions.

A. Local Agency Incentive Payments

In an effort to offset the local agency's administrative costs for program integrity activities and staff and provide cost savings through increased investigation and collection of Medicaid overpayments, the Division of Health Benefits (DHB) implemented an incentives program for collections of client responsible overpayments effective February 1, 1997.

1. The agency receives monthly incentive payments from the DHB based on collections for client responsible overpayments.
2. The calculation for agency's incentive payments is based on one-half of the non-federal share of collections for client responsible medical assistance overpayments.
3. The state, and federal reimbursement rates vary slightly from year to year. The agency's incentive is based on the actual state and reimbursement rates that were in effect during the overpayment period captured in NC FAST.
4. Incentive payments are based on collections keyed into NC FAST. Collections are passed from NC FAST to the Medicaid Accounting System and incentive payments are credited back to the agency through the monthly Medicaid Adjustment Register.

B. State law requires the following actions regarding reporting the status of fraud/overpayment cases:

1. The agency must enter a referral in NC FAST for each fraud complaint that is initiated or investigated. Also, agency is required to establish an overpayment claim within 180 days from the date of discovery. The NC FAST PI Portal has been designated as the system to track the local agency's Program Integrity activities and generate reports.
2. Data in NC FAST on PI referrals, overpayment claims, and funds collected, on overpayments are available on reports generated in NCXPTR and NC FAST, as they are entered. Refer to the job aid, PI-Reports, for a list of reports accessible to the local agency.

XVI. NC DEBT SETOFF (TAX INTERCEPT) CRITERIA FOR MEDICAID CLAIMS

A. BACKGROUND

1. The purpose of this section is to explain the procedures for North Carolina Debt Setoff Collection for Medicaid and NCHC claims in NC FAST. North Carolina General Statute 105A establishes a policy that allows the Department of Health and Human Services (DHHS) to identify debtors who owe money to the Medicaid, Work First and/or Food & Nutrition Services (FNS) programs as the result of Intentional Program Violations (IPV) or Inadvertent Household Errors (IHE).

This Statute allows DHHS agencies to collect the debt by intercepting income tax refunds through the North Carolina Department of Revenue (DOR).

2. General Statute 105A-12 requires programs within State agencies to register with DOR before they can participate in the NC Debt Setoff Collection Act. DOR then assigns an "Agency Code" to each program type on the date they register. Therefore, each program has priority for tax intercept based on the date each program registered with DOR.

If a debtor who meets the criteria to have his taxes intercepted has claims in multiple DHHS programs that are submitted to DOR at the same time, the intercept of the tax refund is applied in the following order for each program type:

Child Support	Non-NC FAST
Medicaid – Third Party Recovery (TPR)	Non-NC FAST
Food and Nutrition Services	NC FAST
Work First/AFDC	NC FAST
Medicaid/NC Health Choice	NC FAST

The **Division of Health Benefits** applied for a second agency code for Medicaid since debtors are submitted to DOR separately for **NC FAST** and TPR. Since 80% of Medicaid's tax intercepts are for TPR Medicaid, **NC FAST** Medicaid was assigned the newest DOR agency code.

B. NC DEBT SETOFF PROCESS IN NC FAST

1. The **NC FAST** NC Debt Setoff process consists of three phases from the time of selection of eligible debtors until a tax refund is intercepted and the payment applied in **NC FAST**. The PI Investigator needs to maintain the data in **NC FAST** to assure debtors are not inappropriately selected for debt setoff.
 - a. The selection process for NC Debt Setoff is evaluated separately for each program type: Medicaid/NCHC, **FNS** and Work First/AFDC.
 - b. The entire process takes approximately seven weeks from start to finish.
 - c. A new selection cycle starts each week as all claims in **NC FAST** are evaluated to determine if they meet the criteria for the debtor to be selected and submitted to DOR for possible tax intercept.
2. The three phases of the NC Debt Setoff process are:

Phase I - Selection of Eligible Claim Debtors and Submission of Files to DOR

Phase II - Tax Intercept and Notice to Debtor

Phase III - Application of Payments in **NC FAST** and/or Refunds to Debtors

C. Phase I - Selection of Debtors and Submission of Files to DOR

1. Each Medicaid claim is evaluated separately to determine if it meets the criteria for selection for NC Debt Setoff for Medicaid. To be selected a debtor's claim(s) must meet the following criteria:

- a. The debtor must have an SSN (non-duplicated) in **NC FAST/CNDS**.

In the event a debtor is found to have the same SSN as a different person in CNDS, then the debtor will be rejected from the NC Debt Setoff selection process.

- b. The claim must be in **Active** collection status
 - c. The claim type must be IPV or IHE.
 - d. The claim must be delinquent. A claim is delinquent when the following conditions are met:
 - (1) The claim Establishment Date must be greater than 60 days old. This calculation is made at the time the NC Debt Setoff Selection process runs using the 'current date' for comparison.
 - (2) No cash payments have been made on the claim in more than 60 days.
 - e. The total current claim balance for the debtor's eligible claim(s) must be at least \$50.
 - (1) If a debtor has one Medicaid or NCHC claim, the claim balance must be at least \$50; or
 - (2) If a debtor has two or more Medicaid and/or NCHC claims that meet all of the criteria for selection, then the total current balance for all eligible claims are combined into one amount and the total combined amount must be \$50 or greater.
2. The criteria listed above are evaluated for each program type and for each claim separately. This means the debtor may have multiple claims within a program type, such as Medicaid/NCHC, but some of the claims may not meet the criteria for intercept. The debtor may also have claims for more than one program type (i.e., Medicaid and **FNS**) but only claims for one program type may meet the criteria for intercept. It is possible for a debtor to be submitted for intercept for all three program types at the same time.
 3. Claims are evaluated every week to determine whether a debtor's claim(s) meet all the criteria for the debtor to be selected for submission to DOR for possible intercept. This process means debtors are constantly being submitted to DOR for possible intercept of any refund due the debtor.
 4. Debtors are submitted to DOR based on the debtor's Social Security Number (SSN) that exists in **NC FAST**.

If a debtor does not have a valid SSN in **NC FAST/CNDS**, the debtor cannot be submitted for tax intercept. In addition, if an invalid SSN is in **NC FAST/CNDS**, it is possible that a tax refund of another individual will be incorrectly intercepted.

D. Phase II – Tax Intercept And 30-Day Notice to Debtor (DSS-8653)

1. Mailing Notice to DOR Address

- a. Once the tax intercept has occurred, DOR will forward a file to **NC FAST** for each program type with the individual debtor information for each successful intercept and the dollar amount that was intercepted for each debtor.
- b. The [DSS-8653](#) Notice to Debtor, is mailed to the debtor's last known mailing address reflected in **NC FAST**.
 - (1) If the notice is returned to the **local agency** by the postal service, forward the notice to the mailing address shown in the **agency's** file, if different.
 - (2) If the notice cannot be successfully delivered by the postal service, file the returned notice in the case record.
 - (3) The intercept will be processed since the notice was sent to the best available address known to the agency.
 - (4) DOR notifies the debtor that their tax refund has been intercepted, in whole or in part using **the address listed on the debtor's tax return**.
- c. The **EPI431**, NC Debt Setoff 30-Day Notice Report lists all debtors that were intercepted, and all information listed on notice.

2. Content of Notice to Debtor

The Notice to Debtor, [DSS-8653](#), explains the agency's basis for the claim to the debtor's NC tax refund and the intent to apply the refund against the Medicaid, FNS, and or Work First/AFDC debt(s) owed to the **agency**.

- a. The Notice informs the debtor of his right to contest the tax intercept by filling a written Petition for a hearing with the Office of Administrative Hearings (OAH) within 30 calendar days from the date of the Notice to Debtor.
 - (1) General Statute 105A-8 specifies that the debtor cannot contest the action if the debt has been previously litigated in a court proceeding.
 - (2) Refer to E., below, for the specific criteria for debtors appealing to the intercept.
- b. The Notice specifies that failure to request a hearing by the 30th day results in setoff of the claim(s) with the intercepted tax refund.

- c. The notice includes the **last four digits of their** social security number as it exists in **NC FAST/CNDS**, the debtor's name and the last known mailing address in **NC FAST**.

This information, as well as the programs that received the intercepts, are provided on the **EPI431**-NC Debt Setoff 30-Day Notice Report.

- d. The Notice reports the current balance owed for the outstanding claim(s) that meets the requirements for NC Debt Setoff for FNS, AFDC/Work First, and/or Medicaid/NC Health Choice that is successfully intercepted. The totals shown are not the amount that is intercepted, but the amount of the eligible claim balance(s) owed to each program that was intercepted.

- (1) The amount owed is shown for each program type, as well as, the combined total amount owed if the debtor has eligible claims for more than one program type that is successfully intercepted.

Example: The debtor has eligible delinquent claims for AFDC/Work First of \$200 and Medicaid of \$3,000. The tax refund that is intercepted is \$500. The Notice will show the \$200 amount for AFDC/Work First and the \$3,000 amount for Medicaid since the tax refund was large enough to intercept an amount for both programs.

- (2) Only claim balances for the program type that is successfully intercepted is printed on the Notice to Debtor and the **EPI431** NC Debt Setoff 30-Day Notice Report.

Example: The debtor has eligible delinquent claims for **FNS** of \$200 and Medicaid of \$600. The tax refund that is intercepted is \$100. The Notice will not show the \$600 amount for Medicaid since the tax refund was not large enough to intercept an amount for the Medicaid claim.

- (3) Claims that do not meet the requirements for debt setoff are not included in the totals; therefore, the debtor's actual debt for the program type may be more than is reflected on this notice.

- e. The debtor is informed to contact the local agency's Program Integrity Section as listed on the notice if they have questions concerning the intended action.

3. Multiple Notices

- a. It is possible for a debtor to receive multiple copies of the Notice to Debtor if he has eligible claims with different **local agencies** that are successfully intercepted.
- b. Each Notice will provide the debtor with the **agency's** address and telephone number for the **agency** with ownership for the claim(s) shown on the notice.

- c. The 'balance eligible for intercept' for each program shown on the Notice is the cumulated balance(s) for the eligible claims for that **agency** only. It is possible for the cumulated balance shown for each program type to be less than \$50 when there are multiple claims in different **agencies** for the same program type.

Example: The debtor has eligible Medicaid claims of \$30 in **agency** A and \$35 in **agency** B that were successfully intercepted. Although the amounts shown on the notice for each **agency** is less than \$50, the combined total of the two claims is greater than \$50.

- d. The **EPI431** NC Debt Setoff 30-Day Notice Report lists the debtor has eligible claims that were successfully intercepted in multiple counties. Refer to d., below, for detailed information about this report.

4. NC Dept Setoff 30 Day Notice Report (**EPI431**)

The **EPI431** lists the debtors whose taxes were successfully intercepted and were mailed the 30-Day Notice to Debtor. The report is produced for each Investigator within the **local agency**. The report is also a useful tool for answering questions from a debtor.

E. Appeal Requests

1. Appeal Requirements

- a. The debtor has 30 calendar days from the date of the Notice to Debtor to request a hearing to contest the tax intercept.
- b. The debtor must request a hearing by filing a written Petition with the Office of Administrative Hearings (OAH) and meet all of the following requirements.
 - (1) The request for a hearing must be mailed with postage prepaid and properly addressed or delivered by the 30th day after the date on the Notice.
 - (2) The debtor must mail or deliver the original and one copy of the Petition requesting the hearing to OAH at the following address:

Mailing Address:	Physical Address:
Office of Administrative Hearings	Office of Administrative Hearings
6714 Mail Service Center	1711 New Hope Church Road
Raleigh, NC 27699-6714	Raleigh, North Carolina 27609
(919) 431-3000	(919) 431-3000

- (3) The debtor must also mail or deliver a copy of the Petition to the agency named as the Respondent on the petition, which is the DHHS, listed on the Notice to Debtor.

- (4) If the debtor does not request a hearing by the 30th day, the debtor has waived the opportunity to contest the action and the intercepted amount of the tax refund will be applied to the claim that is owed to the **local agency** on the 35th day.
- c. If the debtor waives their right to a hearing, send a request **on agency's letterhead to the DHB PI Beneficiary Fraud Consultant. The request should include the Debtor's name, PDC number, balance and the tax intercept amount. Once the request is keyed, NC FAST** will process the payment immediately.

The debtor may wish to waive their right to the appeal if they agree with the intercept and their current outstanding balance is less than the intercepted amount since **NC FAST** will immediately process the payment and refund due to the debtor. This can occur if a payment was made to reduce or pay off the claim after it was submitted to DOR for the intercept.

2. Debtor Calls **Agency** to Request a Hearing

- a. If the debtor wants to contest the tax intercept, the debtor must request the hearing through OAH by filing a Petition for the hearing.
- b. Inform the debtor that he must contact OAH at the address or telephone number shown above or shown on the Notice to Debtor that they received. OAH will provide the debtor with information regarding the specific requirements to request the hearing.
- c. The debtor is required to file an original and one copy of the petition with OAH and a copy must be served on the opposing party, which is the **agency**.
- d. See the "Petition for a Contested Case Hearing" and the OAH instructions for completing the form.
- e. Additional information regarding OAH is available at:
<https://www.oah.state.nc.us/hearings>.

3. Debtor Files a Petition for a Hearing

- a. The **DHB PI Beneficiary Fraud Consultant will add the litigation indicator on the NC FAST Debtor's Indicator tab** upon receiving notification of a debtor's Petition for a hearing from the **agency** or the Attorney General's office. An entry will be made by the 35th day from the date of the Notice to Debtor if notification is received timely.

If the **litigation** indicator is not keyed into **NC FAST** by the 35th day, the intercepted amount will be applied as a payment against the eligible claim(s).

- (1) When the **litigation indicator** is present on the **NC FAST Debtor Indicators tab**, a payment/refund cannot occur as the debtor is still in the "Request Appeal" stage.

- (2) The **indicator** will remain unchanged until the assigned **DHB PI Beneficiary Fraud Consultant** receives written notification of the tax appeal decision from the Attorney General's Office.
 - (3) If the appeal is in favor of the debtor, the assigned **DHB PI Beneficiary Fraud Consultant** will immediately release the tax refund to begin the **refund process** as interest is accruing for every day the money is held until the intercepted funds are refunded to the debtor.
- b. The valid DOR Offset statuses for the NC Debt Setoff Intercepts screen are as follows:

Pending **Applicable to:**

- DOR offset pends for 35 days (normal process)
- Litigation Hold (Offset pends until hearing conclusion).

Posted **Applies to:**

- DOR offset has been applied to claim(s)
- Debtor waives right to a hearing and request offset post immediately. (PI staff must send formal request to State)
- Litigation decision is in favor of County. Offset posts to claim(s)

Refunded **Displays for:**

- Refund is released to debtor
- Refund can be generated by system or keyed manually by State staff

4. Hearing Decision Reached

Once a hearing decision is reached by OAH, the **DHB PI Benefits Fraud Consultant** will update the **litigation** indicator on the Debtor Indicators screen based on the decision.

- a. If the hearing decision is in favor of the **local agency**, **NC FAST** will process the payment/refund immediately and the is removed.
- b. If the hearing decision is in favor of the debtor, the refund process will begin once the **litigation indicator** is removed. The DHHS Controllers Office will issue a manual refund to the debtor, plus any interest accrued and possible collections fee.
 - 1. Since no payment is credited through **NC FAST** while there is a **litigation indicator showing**, the **DHB PI Beneficiary Fraud Consultant** must remove the indicator.
 - 2. Any debtor with a **litigation indicator** on the Debtor Indicator's screen will not be eligible for DOR selection until the assigned **DHB PI Beneficiary Fraud Consultant** removes the block. The debtor will appear on the **EPI429** Claims exempt from NC Debt Setoff Report until the indicator has been removed.

F. Phase III - Application of Payments in **NC FAST** and Refunds

1. Schedule for Applying Payments

The process for applying payments will run every business night searching for any intercepts that are eligible to be applied to claim balances. This will occur when the appeal process has completed. This process will occur after the 35th day if no appeal is requested or if the debtor has not waived their appeal rights or the hearing or **NC FAST**.

2. How Payments Are Applied

a. **NC FAST** receives three files from DOR, one for each program type: Medicaid/NC Health Choice, **FNS** and Work First/AFDC. Once the appeal process has been fulfilled, **NC FAST** applies the payment across all eligible claims that were initially selected for submission to DOR for each program type that has an intercept.

(1) DOR intercepts money for one program type at a time for any given debtor's SSN based on the program's priority number.

(2) If the tax refund available to be intercepted from DOR is larger than the debt owed for the eligible claim(s) for a single program type, then **NC FAST** can potentially receive an intercept for all three program types for any given debtor.

Example: Amount available for intercept is \$1,000. The debtor has eligible claims submitted to DOR for FNS for \$400, WF for \$200 and MA for \$700. The first intercept is for FS. Since there is \$600 still available for intercept, the next intercept is for WF. Since \$400 remains to be intercepted, the next intercept is for MA.

If the claim balances remain the same at the time the payments are applied in **NC FAST**, the FS and WF claims will each be paid in full. The current balance for the MA claim will be reduced to \$300.

(3) If the amount intercepted from DOR is for eligible claims for one program type only, then no portion of the amount can be applied to any additional claims for that program or to the claims for any other program type.

Example: If an amount is intercepted for the Medicaid program and a portion of the refund must be refunded to the debtor, this excess amount cannot be applied to any additional Medicaid claims that were not eligible to be submitted for tax intercept. In addition, it cannot be applied to any Food Stamp or Work First claims. The excess amount must be refunded to the debtor.

- b. The intercepted amount can be applied to one or more claims within a program type, provided the claims were originally selected for NC Debt Setoff.
 - (1) When the payment for the intercepted amount is applied, the payment will be applied to the oldest claim first based on the Establishment Date of the claim.
 - (2) The balance of the intercepted amount will be applied to the remaining claims based on the Establishment Date for each claim.
 - (3) If there are two or more claims with the same Establishment Date, the payment will be randomly applied to one or more of the claims.
- c. If the claim is paid in full by the intercepted funds, the claim is closed in **NC FAST**.
- d. If the claim is not paid in full, the outstanding balance is reduced by the payment amount.
- e. The method of payment for all NC Debt Setoff payments will display as “DOR” on the **Financial Screens**. Refer to **NC FAST Job Aid, PI-View a Payment on a Product Liability Case**.

3. NC Debt Setoff Indicators

After the intercepted amount has been applied, refunded or both, **all of** the claims that were included in that particular intercept will have their NC Debt Setoff Indicator **reset on the Debtor Indicator tab**. This will allow the unpaid claims with an outstanding balance to be evaluated for future DOR selection.

4. Refunds to Debtors

- a. The refund checks will be processed weekly. All refunds will appear on the **EPI107, NC DEBT FIN RFD** report. This report shows the amount that is to be sent to the debtor for DOR over collections, as well as the date the refund check will be written.

Refund checks are written and mailed to the debtor by the DHHS Controllers Office.

- b. If the tax intercept amount exceeds the total amount owed by the debtor for the program type at the time the payment is applied to the eligible claim(s), the remainder of the intercepted amount must be refunded to the debtor. This will not occur unless a payment is made on the claim after it is submitted to DOR for intercept.
- c. If the status of the debtor's claim(s) changes after the claim is selected for intercept and submitted to DOR, the payment will still be applied to the selected claims if there is an outstanding balance.

- (1) If the intercepted amount is greater than the amount of the debt at the time the payment is applied to the claim(s), the over-collected amount, as well as accrued interest, will be refunded to the debtor.
 - (2) The collection fee will not be refunded to the debtor.
- d. There are exceptions that may come about between the time the debtor was intercepted by DOR and the time the application of payment actually occurs. These exceptions will appear on the Exception Log Report received by the State for further investigation. They include:
- (1) The debtor has been deleted.
 - (2) The claim changes to Closed Status, "CL" (i.e. Balance gets paid off).
 - (3) The claim changes to some other status (i.e. Transfer Status, "TR", applicable to FNS and WF).

G. REPORTS FOR NC DEBT SETOFF

There are several reports available in **NC FAST** that track claims as the debtors are selected for intercept of their North Carolina tax refunds. Relevant reports include the following:

1. **EPI429** Records Exempt from NC Debt Setoff
2. **EPI213** Claims Selected for NC Debt Setoff
3. **EPI431** NC Debt Setoff 30-Day Notice Report

XVII. NORTH CAROLINA EDUCATIONAL LOTTERY INTERCEPTIONS

A. Background

The NC Educational Lottery (NCEL) interception is a process in which lottery winnings are intercepted to repay IHE and IPV claims. Lottery winnings must be at least \$600.00 for an interception to take place.

B. NCEL Intercept Requirements

1. NCEL uses the same rules for selecting eligible debtors as the North Carolina Department of Revenue (DOR). It also applies the interception in the same order as that of DOR intercepts. Refer to XVII.
2. The Department of Health and Human Services (DHHS) provides a file to NCEL each week. Each weekly file replaces the previous week's file. It reflects **NC FAST** latest claim balances and drops or adds claims depending on the current balance and selection criteria.

3. NC FAST sends a notice, [DSS-8234](#) Notice to Debtor, to the debtor regarding the interception and the claim balance. The notice advises the household of one of the following:
 - a. The amount intercepted, applied, and that the claim is paid in full or,
 - b. The amount intercepted, applied, and the remaining balance of the claim or,
 - c. The amount intercepted, applied, and the amount to be refunded.
4. Unlike DOR interceptions, the debtor does not have a right to a hearing or appeal regarding the NCEL interception.

XVIII. NORTH CAROLINA TITLE XIX MEDICAID/NCHC **BENEFICIARY PROFILES**

A. Purpose of the **Beneficiary Profiles**

The Medicaid/NC Health Choice **Beneficiary** Profile provides detailed claims information of medical expenditures and services Medicaid paid on behalf of the authorized **beneficiary**. **This section contains the process to follow in requesting a beneficiary profile as well as a detailed explanation for the information listed. In compliance with HIPAA regulations, DHB will only release the beneficiary profile to individuals authorized to obtain the protected health information.**

B. Profile Requests for **Client Responsible Overpayment**

1. Upon determining the period of ineligibility, request a **Beneficiary** Profile for each ineligible **beneficiary** to determine the amount of medical claims Medicaid paid.
 - a. Complete a [DHB-7063](#), **Beneficiary** Request Sheet for each **NC FAST** case. The form is located on the [DHHS Policies and Manuals Website for Health Benefits/NC Medicaid](#).
 - b. Instructions for completing the [DHB-7063](#) are located on the back side of form. Mail or fax page 1 of the completed form to:

Division of Health Benefits
OCPI/Quality Assurance Section - 18
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax 919-800-3186

- c. **Profiles are normally available the Monday after the request is submitted to DHB. They are loaded within 2 weeks of the request to the local agency's Secure folder in NCTRACKS under Report2Web.**

If the profile has not been received within 3 weeks of the original request, send an email to your agency's **DHB PI Beneficiary Fraud Consultant** to check the status of your original request. Include the referral number, fax submission date

and the service date(s) requested in the email. The Consultant will advise whether your request was received or if it needs to be resubmitted.

2. Request for Family Planning **Program (FPP) Profiles**

a. When the **beneficiary** is ineligible for the original Medicaid program category received, they may be found eligible for FPP. The investigator must request an FPP profile to exclude these charges from the overpayment. The FPP profile is requested using the [DHB-7063](#) and marking the following:

- (1) Check the “YES” box by the question, “Is this request for Family Planning **Program** profiles?”
- (2) Check the **FPP** box next to the Dates of Service the profile is needed.

DO NOT order an FPP profile if the original coverage was MAFD.

b. The **DHB PI Beneficiary Fraud Consultant** will order the profile from **NCTRACKS** and review to determine which claims are **FPP** related services. The **Consultant** will prepare a letter to advise the investigator of the total amount of **FPP** claims. The **FPP** claims amount listed must be deducted from the total overpayment amount.

3. Requests for Expedited Profile due to Excess Reserve Overpayments

a. When termination is proposed for an authorized case due to excess reserve, it is critical that the investigator quickly verify any prior months of ineligibility and, if there is a period of ineligibility, to quickly establish the overpayment amount before the **beneficiary** reduces reserve on other expenditures.

b. Paid claims information is viewable to DHB staff prior to generating a profile.

c. Contact your county assigned **DHB PI Beneficial Fraud Consultant** to request the current amount of paid claims reflected in **NCTRACKS** for the overpayment period. There must be an open Medicaid referral in **NC FAST** for excess reserve to perform this request. The excess reserve case must meet the following criteria:

- (1) Termination is proposed due to excess reserve and the Investigator verifies there is a period of ineligibility for the time the **beneficiary** was authorized.
- (2) The Investigator needs to notify the **beneficiary** of the approximate overpayment amount before the **beneficiary** reduces reserve by spending it elsewhere.

d. All telephone requests must be followed up with a [DHB-7063](#) via mail or faxed to the DHB Office of Compliance & Program Integrity (OCPI)/Quality Assurance Section.

Example: The caseworker verifies from the FRR that a MAF **beneficiary** is over reserve by \$8,000 due to unreported assets. Timely notice is sent to propose termination for ongoing coverage. It is also verified that the **beneficiary** was ineligible for Medicaid for the prior five months of authorization due to excess reserve. There is a Medicaid overpayment if claims for medical expenses were paid during the period of ineligibility.

The Investigator contacts **DHB** by telephone and quickly establishes \$9,870 in claims paid to date for the period of ineligibility. The **beneficiary** is able to reduce reserve for ongoing coverage by paying the overpayment amount. If the **beneficiary** quickly spends the excess reserve for other purposes to avoid case termination, there may be no funds left with which to repay the overpayment.

C. Request for **Beneficiary** Profiles other than to Collect Overpayments

1. Guardian Ad Litem or GAL

The guardian ad litem or GAL has the authority per **NC G.S. 7B-601** to "obtain any information or reports, whether or not confidential, that may in the guardian ad litem's opinion be relevant to the case. No privilege other than the attorney-client privilege may be invoked to prevent the guardian ad litem and the court from obtaining such information. The confidentiality of the information or reports shall be respected by the guardian ad litem and no disclosure of any information or reports shall be made to anyone except by order of the Court or unless otherwise provided by law."

To ensure confidentiality, the GAL should send an original "True Copy" of the GAL court order, the "Order to Appoint or Release Guardian Ad Litem and Attorney Advocate", to the attention of your **DHB PI Beneficiary Fraud Consultant** at:

Division of Health Benefits
OCPI/Quality Assurance Section - 18
2501 Mail Service Center
Raleigh, NC 27699-2501

Accompanying the GAL court order should be a letter from the GAL or the Attorney Advocate, specifically including the following:

- a. The names of the **beneficiaries** for whom Medicaid records are needed, their CNDS ID number and social security number without this information the request cannot be processed.
- b. The dates of service needed.
- c. Signature of GAL, along with a business phone number where s/he can be reached.
- d. **DHB/OCPI** will send the profile via certified mail to the GAL at the court in which they serve, or hand delivered requiring proof of identity upon delivery.

2. Social Workers

Social workers may ask the PI investigator to order profiles for reasons other than for those allowed under confidentiality guidelines. These requests usually come from Protective Services Workers who may need the medical records to use in court to show neglect or abuse. To order these profiles:

- a. The social worker must complete [DHB-7098](#) local agency Authorization to Disclose Health Information. The agency's director or his designee must sign the form.
- b. Mail or fax the completed [DHB-7098](#) to the:

Division of Health Benefits
OCPI/Quality Assurance Section - Box 18
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax (919) 800-3186

3. Beneficiaries:

When a beneficiary or his authorized representative requests the beneficiary's Medicaid profile:

- a. Advise the beneficiary or his legal representative to contact the **DHB Office of Compliance and Program Integrity Call Center at (919) 527-7749**, or the local agency may assist with ordering the beneficiary's profile. Instruct the beneficiary or authorized representative to complete and sign the [DHB-7097, Beneficiary](#) Authorization to Disclosure Health Information form. Fax the completed form to **(919) 800-3186**.
- b. **DHB/OCPI/QA** will process the request and forward the Medicaid/NCHC **Beneficiary** Profile to the local **agency within three weeks**. A letter will accompany the profile with instructions for **beneficiary** and/or their **authorized representative**. The **beneficiary** or their authorized representative must physically pick up the profiles.
- c. Prior to releasing the profile, the local agency must require proof of identity.
- d. If the **beneficiary** and/or their authorize representative does not pick up the profiles within 30 days from the agency's contact, the agency should shred the profiles.

4. Law Enforcement

Local Law Enforcement officers may ask the fraud investigator for a **beneficiary's** medical information for an investigation. Medical information may not be released without a court order. Refer these calls to **NC DHHS, General Counsel's Office at (919) 855-4890**.

5. Attorneys

Attorneys may contact a **local agency** investigator to obtain information on medical claims Medicaid paid on behalf of a **beneficiary**. Refer the attorney to **DHB's Third Party Recovery** section at **(919) 527-7690**.

6. All Other Requests

If other requests for profiles are received and this section does not address how to handle the requests, refer the requester to **DHB's Office of Compliance and Program Integrity's Call Center** at **(919) 527-7749**.

D. Information Provided on the Medicaid/NCHC Beneficiary Profile

1. A **Medicaid** Profile is produced for each CNDS ID number requested during the date range listed on the [DHB-7063](#).
 - a. **It includes a description of the service rendered, the date of service, billing provider number, payment status, billed amount and the amount paid by Medicaid.**
 - b. The **Provider Summary** page lists the total claims paid to date for each provider during the overpayment period.
 - c. **The Payment Summary page lists the total claims paid by the month of the claim payment for each month in the overpayment period.**
 - d. The **Date of Service Summary** page shows the total claims paid **by the month** the service was rendered for each month of the overpayment period.
 - e. For most Medicaid cases, the overpayment amount is established based on the monthly totals reflected on the **Date of Service Summary** page.
 - f. In cases where the totals on the Provider Summary page and Date of Service page are different, **use the lesser amount of the two**.
2. **Claims Payment History produced on Beneficiary Profiles**
 - a. **Claim payment history produced on the profile are for the date range requested. For most claims NCTRACKS retains claims history for 10 years from the date of payment.**
 - b. Certain medical procedures and services have limitation criteria that require that the claim data be retained for a longer period (i.e. once in a lifetime procedure) are retained on the claims system forever.

Claims with limitation criteria are retained for the period of time required (i.e. dentures, eyeglasses)

3. Profiles include monthly contractual fees paid for beneficiaries with active enrollment such as the Per Member, Per Month (PMPM) payments for all Primary Care Physicians (PCPs) and Capitation fees for managed care entities. These charges are treated the same as any other paid claims and are included in determining the amount of the overpayment. Include these fees when establishing the overpayment regardless of whether the **beneficiary** received any additional services.
4. Requesting the Initial **Beneficiary** Profile and the Follow-Up Profile.
 - a. Providers must file a claim for payment for a Medicaid covered service within 365 days of the date of service. Refer to [MA-3530](#), Corrective Action and Responsibility for Errors, for exceptions to the filing time limit.
 - b. If any portion of the overpayment period is within the past 12 months when the initial profile is requested, all claims may not have been paid since providers have 12 months to file a claim.
 - c. Request a **follow-up** profile in the **13th month** after the last month of the overpayment period to obtain all paid claims information when needed. Each new profile provides the total claims paid for the overpayment period as of the date the profile was **generated**. Refer to XI.A.1.a. for procedure to follow if the amount of the overpayment changes.
 - d. The **EPI470** Medicaid Profile Follow-up Case Management Report identifies claims for which a follow-up profile must be requested. This **NC FAST** report is generated on the last working day of the month and is available on the first working day on the next month.

E. How to determine the overpayment amount

1. Complete a [DHB-7063](#) to request a **beneficiary** profile for each individual in the case in which there is a period of ineligibility. Request claim information for each ineligible **beneficiary** based on the actual months of ineligibility for Medicaid.
2. Determine the amount of claims paid during the period of ineligibility for each ineligible individual.
 - a. For all Medicaid **beneficiaries** verify the amount of paid claims on the Date of Service Summary for each ineligible **beneficiary** in the **NC FAST** claim.
 - b. For reserve cases, refer to VIII.C., above.
 - c. For deductible cases, refer to VIII.B., above.
 - d. For NCHC **beneficiaries**, determine the overpayment according to IX., above.

F. How to Read the Medicaid **Beneficiary Profile**

1. **Beneficiary Profile Page Header and Claim Header**

The following Page Header information is reflected on every page of the current and purged profile and the Claim Header information is reflected on each page of the claim detail pages.

Profiles are generated during provider Checkwrite. Claims listed on profile were adjudicated prior to or during the Checkwrite.

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 12/01/9999
PAYER: DHB	NTRACKS	PROCESS TIME: 00:00:44
	AS OF: 12/01/9999	PAGE: 500
RECIPIENT HISTORY PROFILE REPORT		
RECIPIENT (123456789L) CURRENT PROFILE PG- 50		
REQ BY CLERK=C999VOLD REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNPOQRSTUVWXYZ DATES=03/01/9999- 11/30/9999		
BASE ID=004330736 GENDER=F NAME=RONA, COCO HIC 000000000E MBI DOB=03/01/2020 DOD=		
-----CLAIM-----	PROV NBR	ATTN NBR . PS ADM-FIN DTE AT AH DH BILLED PAT-LIAB SPEND-DWN PAYABLE NET-PD
CT TCN	ST B AUTHORIZATION	DIAG DESC DIAG DESC DIAG DESC
FIN PAYER RD-----		
T	ST FROM-DATE-TO PL QTY PROC TOOTH NBR SURFSRV IM EOB BILLED REIM CO-PAY OTH-INS PAID	
L	PGP PAC MODIFIERS DESC PCT	

2. **Claim Page Header Description (Lines 1-9)**

FR66200-R0010	The report number used internally to identify reports to the system and to the users
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS	The owner and name of the system from which the claims were retrieved
PROCESS DATE	The date the information was processed. (In MM/DD/YYYY format)
PAYER	Denotes the Division's budget from which the claims listed are paid
AS OF DATE	This represents the Check write date for claim paid during this payment cycle. Profiles are generated during Check write. Claims listed on profile were adjudicated prior to or during the checkwriter.
PAGE	The page number within the entire job of profile requests generated during the Checkwrite.
BENEFICIARY	The CNDS ID number for which claims are requested.
CURRENT OR PURGED PROFILE PG	Indicates the type of profile requested and the page number within the beneficiary's profile
REQ BY CLERK	The clerk ID for whom the profile is produced. (C plus the local agency's 3-digit agency number, first initial and first three letters of the requestor's last name.)
REQ FOR	This information determines the type of records presented. Defaults to ALL. Prov = If ALL, all providers selected Claim Type = If ALL, all claim types are selected Dates = The range of dates of services requested.
BASE ID	The unique number assigned to the beneficiary in NCTRACKS.
GENDER	The gender of the beneficiary
NAME	The name of the beneficiary in the eligibility file on the date the profile was produced
HIC	Health Insurance Claim number
MBI	Medicare Beneficiary Identifier. Only displays for beneficiaries who have Medicare.
DOB	The date of birth of the beneficiary
DOD	The death date of the beneficiary, if applicable
CT	Claim type
TCN	Transaction Control Number (aka Claim number) assigned by NCTRACKS
ST	The status of the claim
PROV NBR	Provider Number for the Billing Provider
ATTN NBR	Provider Number for the Provider who rendered service(s)
ADM-FIN DTE	Date provider was paid
BILLED	The total amount billed on the claim by the provider.
PAT-LIAB	The patient liability for this claim.
SPEND -DWN	The amount of spend-down (deductible balance) for this claim.
NET-PD	The amount paid on this claim by Medicaid.
DIAG DESC	The diagnosis number and description

3. Provider Summary Information

The Provider Summary page summarizes all paid claims for each provider number that appears on beneficiary's profile for the period requested. The Summary is sorted in provider number order. The provider number, provider name, number of services, amount billed, and amount paid are presented.

REPORT: FR66200-R0010 PAYER: DHB	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS AS OF: 12/01/9999 RECIPIENT HISTORY PROFILE REPORT	PROCESS DATE: 12/01/9999 PROCESS TIME: 07:33:44 PAGE: 501		
RECIPIENT (123456789L) PROFILE PG- 65				
REQ BY CLERK=C999VOLD REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNQRSTUUVWXYZ DATES=03/01/9999-11/30/9999				
BASE ID=004330736 GENDER=F NAME=RONA, COCO HIC 0000000000E MBI DOB=03/01/2020 DOD=				
PROVIDER SUMMARY INFORMATION				
PROVIDER NUMBER	PROVIDER NAME	NUMBER SERVICES	AMOUNT BILLED	AMOUNT PAID
0955000000	JACKSON CHILDREN	9	517.02	219.89
0063500011	TYVIA RETINA CENTER	6	22,000.00	17,668.25
3400000678	COSTAL EYE CLINIC P	1	240.00	367.58
3403000056	FAMILY PHARMACY	18	2,161.28	831.02
3406000043	SOUTHREN NEPHROLOGY A	3	435.00	172.10
3406000000	CARRYING CARDIOLOGY	1	125.00	57.23
3245000099	LABORATORY CORPORATI	1	114.00	19.80
6202040	ACCESS GRANTED INC	5	50.60	50.60
6767676	MEDSOLUTIONS INC	5	73.70	73.70

PROVIDER NUMBER	Each provider which appears on the report. Report is sorted in provider number order.
PROVIDER NAME	The provider's name as it appears on the Provider Master File
NUMBER OF SERVICES	Number of services is calculated by accumulating the quantity fields on most claims type. For crossover claims, one unit is accumulated. On inpatient and nursing home claims, one unit is counted for each accommodation and ancillary code, which appears, on the claim. On drug claims, one unit is counted for each NDC drug dispensed.
AMOUNT BILLED	The total amount billed, accumulated from the header, by this provider
AMOUNT PAID	The total amount paid, accumulated from the header, to this provider

4. Payment Summary

The Payment Summary provides a monthly summary of paid claim information for the Medicaid **beneficiary**. The Summary provides the amounts paid the time period requested based on the **month of payment**. This report is produced at the same time as the Claims Information and the Provider Summary Information.

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES		PROCESS DATE: 12/01/9999
PAYER: DHB	NCTRACKS		PROCESS TIME: 07:33:44
	AS OF: 12/01/9999		PAGE: 502
RECIPIENT HISTORY PROFILE REPORT			
RECIPIENT (123456789L)	PROFILE PG- 66		
REQ BY CLERK=C099VOLD	REQ FOR PROV= ALL	CLAIM TYPE = 012345689ABCDEFGHIJKLMNQRSTUWXYZ	DATES=03/01/9999-11/30/9999
BASE ID=004330736	GENDER=F NAME=RONA, COCO	HIC 0000000000E	MBI DOB=03/01/2020 DOD=
PAYMENT SUMMARY			
	PAID DATE	AMOUNT BILLED	AMOUNT PAID
	08/9999	7,677.18	3,608.49
	09/9999	20,049.26	3,579.55
	10/9999	6,792.98	3,458.69
	11/9999	12,291.63	3,778.38
	12/9999	7,935.66	2,265.96
	01/2000	4,756.11	2,769.09
	TOTAL	42,514.71	19,460.16

PAID DATE	The Month in which the services were performed
AMOUNT BILLED	The total amount billed by the provider for the services performed during the month
AMOUNT PAID	The total amount paid by Medicaid for services performed during the month
TOTAL	Total amount billed and total amount paid.

5. Date of Service Summary

The Date of Service Summary provides a monthly summary of paid claim information for the Medicaid **beneficiary**. This page provides the monthly amounts billed and paid for the period requested based on **dates of service**. This report is produced at the same time as the Claim Information and the Provider Summary Information.

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 12/01/9999	
PAYER: DHB	NCTRACKS	PROCESS TIME: 07:33:44	
	AS OF: 12/01/9999	PAGE: 503	
RECIPIENT HISTORY PROFILE REPORT			
RECIPIENT (123456789L)	PROFILE PG- 67		
REQ BY CLERK= C999VOLD REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNOPQRSTUVWXYZ DATES=03/01/9999 11/30/9999			
BASE ID=004330736 GENDER=F NAME=RONA, COCO HIC 0000000000E MBI DOB=03/01/9999 DOD=			
DATE OF SERVICE SUMMARY			
	SERVICE DATE	AMOUNT BILLED	AMOUNT PAID
	08/9999	7,677.18	3,608.49
	09/9999	20,049.26	3,579.55
	10/9999	6,792.98	3,458.69
	11/9999	12,291.63	3,778.38
	12/9999	7,935.66	2,265.96
	01/9999	4,756.11	2,769.09
	TOTAL	42,514.71	19,460.16

PAID DATE	The Month in which the services were performed
AMOUNT BILLED	The total amount billed by the provider for the services performed during the month.
AMOUNT PAID	The total amount paid by Medicaid for services performed during the month
TOTAL	Total amount billed and total amount paid.

6. Cross Reference ID Summary

The Cross-Reference ID Summary provides all ID numbers assigned to recipient that have been merged. Any claims filed under these numbers will appear on the profile for e dates of service requested.

Any ID numbers the **beneficiary** has that have not been merged will not display. A separate profile will need to be submitted for these ID numbers.

REPORT: FR66200-R0010 PAYER: DHB	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS AS OF: 12/01/9999 RECIPIENT HISTORY PROFILE REPORT	PROCESS DATE: 12/01/9999 PROCESS TIME: 07:33:44 PAGE: 504	
RECIPIENT (123456789L)	PROFILE PG- 68		
REQ BY CLERK=C999VOLD	REQ FOR PROV= ALL	CLAIM TYPE = 012345689ABCDEFGHIJKLMNORSTUVWXYZ DATES=3/01/999-11/30/9999	
BASE ID=004330736	GENDER=F NAME=RONO, COCO	HIC 0000000000E MBI DOB=03/01/2020 DOD=	
CROSS REFERENCE ID SUMMARY			
	ALT ID	BASE ID	CROSS REFERENCE ID STATUS
	123456789L	004330736	A
	587654321Q	000803692	S

ALT ID	List all IDs that have been assigned and merged for the beneficiary.
BASE ID	The unique number assigned to the beneficiary in NC Tracks.
CROSS REFERENCE ID STATUS	The status of the ID number. The four available statuses are: A – Active; C – Closed; D-Deleted; M-Merged; S-Soft Delete; V-Void

7. Claim Type Codes

CLAIM TYPE	DESCRIPTION
A	Medicare Part A Crossover (Inpatient)
B	Medicare Part B Crossover (Professional)
C	Health Departments
D	Dental
E	Hearing Aid
F	Nursing Home
G	Hospice
H	Home Health
I	Inpatient
K	Private Duty Nursing
L	Independent Laboratory / Xray
M	Management Fee
N	Adult Care Homes
O	Outpatient
P	Professional
Q	Mental Health
R	Drug
S	Durable Medical Equipment
T	Ambulance (Professional)/Non-Emergency Medical Transportation
U	Medicare Part B Crossover UB (Outpatient)
V	Children's Developmental Services Agencies
W	Financial Claim
X	Optical
Y	Undefined Professional
Z	Undefined Institutional
0	Local Education Agencies
1	Home Infusion Therapy
2	Therapy Services
3	Institutional Ambulance
4	Capitation
5	Rural Health Clinic / Federally Qualified Health Center
6	Personal Care Services
8	Independent Diagnostic Testing Facility / Portable Xray
9	Maternity Event

8. **Claim Status Code**

CLAIM STATUS	DESCRIPTION OF CODE	COUNTABLE OR NON-COUNTABLE
A	Awaiting Fund Availability	Count
C	To Be Denied	Do Not Count
D	Denied	Do Not Count
O	To Be Paid	Count
P	Paid	Count
S	Pend	Do Not Count

G. How to Determine the Service Code for NCFAST

1. Use the **Provider Summary** Information from the **beneficiary** profile to determine the provider number with the highest paid amount. Use the service code for this provider claim type when keying **NC FAST** claims.
2. Locate the provider number for the paid claims on the profile to determine the code for the Claim Type. The claim type code is in the left margin of that provider’s billing information. Determine the Service Code that matches the Claim Type based on the Service Code Chart below. Enter this code on the **NC FAST** claim.
 - a. Determine the Service Code that matches the Claim Type based on the Service Code Chart below. Enter this service code on the **NC FAST** claim.

3. Medicaid Service Codes

SERVICE CODE	CLAIM TYPE	DESCRIPTION
01	A, I, 3	Medicare Part A Crossover (Inpatient), Inpatient, Institutional Ambulance (Emergency)
02	O, U	Outpatient, Medicare Part B Crossover UB (Outpatient)
03	D	Dental
04	R	Drug
05	B, C, L, M, P, Q, V, X, Y, 0, 2, 4, 5, 8	Medicare Part B Crossover (Professional), Health Departments, Independent Laboratory/Xray, Management Fee, Professional, Mental Health, Children’s Development Services Agencies, Optical, Local Education Agencies, Therapy Services, Capitation, Rural Health Clinic/Federally Qualified Health Center, Independent Diagnosis Testing Facility/Portable X-ray
06	G, H, K, S, 1, 6, E	Hospice, Home Health, Private Duty Nursing, Durable Medical Equipment, Home Infusion Therapy, Personal Care Services, Hearing Aid
09	N/A	Medicare Premium (Not found on Beneficiary Profiles)
11	F, N	Nursing Home, Adult Care Homes
67	N/A	NC Health Choice
71	T	Ambulance (professional)/Non-emergency Medical Transportation

H. Examples of Claim Types and Claim Status Codes

1. The following are examples of the Claim Detail Information for various claims.

a. Examples: Claim Types M, 4 (Management and Capitation fees)

REPORT: FR66200-R0010	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	PROCESS DATE: 12/01/9999
PAYER: DHB	NCTRACKS	PROCESS TIME: 00:00:44
	AS OF: 12/01/9999	PAGE: 500
RECIPIENT HISTORY PROFILE REPORT		
RECIPIENT (123456789L)	PROFILE PG- 65	
REQ BY CLERK=C999VOLD	REQ FOR PROV= ALL	CLAIM TYPE = 012345689ABCDEFGHIKLMNOPQRSTUVWXYZ
DATES=03/01/9999-11/30/9999		
BASE ID=004330736	GENDER=F NAME=RONA, COCO	HIC 0000000000E MBI DOB=03/01/2020 DOD=
-----CLAIM-----		
C	TCN	PROV NBR
T	FIN PAYER	ATTN NBR
		PS ADM-FIN DTE AT AH DH
		DIAG DESC
		DIAG DESC
		BILLED
		PAT-LIAB
		SPEND-DWN
		PAYABLE
		NET-PD
	T R D	ST FROM-DATE-TO PL QTY PROC TOOTH NBR SURFSRV IM EOB
	L PGP PAC MODIFIERS	DESC
		BILLED REIM CO-PAY OTH-INS PAID
		PCT
M 1111111111110000	P N	6701006
BILLING NPI		BILL TXNMY 344R00000X
		ATTN NPI 1555555555
		ATTN TXNMY 199900000X
DHB CK=		
EL DAYS		
	001 P 010199 013199	1.000 00
MCAID		.0000 COS=0120
		4.33 .00 .00 .00 4.33
4 2222222222220000	P N	6704000
BILLING NPI		6704000
		BILL TXNMY 333R00000X
		ATTN NPI
		ATTN TXNMY 333R00000X
DHB CK=		
EL DAYS		
	001 P 010199 013199	1.000 00
MCAID		.0000 COS=
		7.76 .00 .00 .00 7.76

C	The Claim (Header)
T	
TCN	Transaction Control Number (aka Claim Number)
FROM-DOS-TO-DOS	The from and through dates of service
S	Status of claim (Header)
T	
DIAG DESC	The diagnosis description. If the diagnosis code billed is invalid, no description will be displayed
BILLED	The amount billed to NC Medicaid
NET PD	The amount Medicaid paid for this claim
LINES 01-XX	Breakdown of Medicaid claim into Line Items (Medicaid Claim Line item 001 is displayed in example)

b. Example - Claim Type R (Drug) & P (Professional)

Drug claims only show the actual date of service. The date of service is the day the prescription is filled.

Professional claims have a “From to Date of Service”.

REPORT: FR66200-R0010 PAYER: DHB	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS AS OF: 12/01/9999 RECIPIENT HISTORY PROFILE REPORT	PROCESS DATE: 12/01/9999 PROCESS TIME: 00:00:44 PAGE: 500
RECIPIENT (123456789L)	PROFILE PG- 65	
REQ BY CLERK=C999VOLD	REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNQRSTUUVWXYZ	DATES=03/01/9999-11/30/9999
BASE ID=004330736	GENDER=F NAME=RONA, COCO HIC 0000000000E MBI	DOB=03/01/2020 DOD=
-----CLAIM-----	PROV NBR ATTN NBR PS ADM-FIN DTE AT AH DH BILLED PAT-LIAB SPEND-DWN PAYABLE	NET-PD
C TCN S B AUTHORIZATION	DIAG DESC DIAG DESC	DIAG DESC
T FIN PAYER T R D-----	T ST FROM-DATE-TO PL QTY PROC TOOTH NBR SURFSRV IM EOB BILLED REIM CO-PAY OTH-INS PAID	
	L PGP PAC MODIFIERS	
R 3333333333330000 P 00125701	013099 15.99	11.80 11.80
BILLING NPI 1861595613 BILL TXNMY		ICD VER 0
DHB CK=9999999999 PRESC=000001111111		
001 P 012299 0 21.000	15.99	.00 3.00 .00 11.80
GEN 39802 GCN 009043 DAYS SUPP 7	NDC 68180012202	DESC CEPHALEXIN 500 MG CAPSULE
P 444444444440000 P N	013099 217.00 .00 .00 88.34	88.34
BILLING NPI 1111111111 BILL TXNMY 193200000X	ATTN NPI 1999999999 ATTN TXNMY 777RH0003X	
DHB CK= C50412 MALIG NEOPLASM OF Z171	ESTROGEN RECEPTOR E8342 HYPOMAGNESEMIA	ICD VER 0
EL DAYS E8351 HYPOCALCEMIA R197	DIARRHEA, UNSPECIF R978 OTHER ABNORMAL TUM	ICD VER 0
001 P 011699 011699 11 1.000 99214 00	N @3	172.00 81.76 3.00 .00 78.76
MCAID H ## OFFICE/OUTPATIENT VISIT EST	.0000 COS=0120	
002 P 011699 011699 11 1.000 85025 00	N @3	45.00 9.58 .00 .00 9.58
MCAID 4 ## COMPLETE CBC W/AUTO DIFF WBC	.0000 COS=	

C T	The claim type (Header)
S T	Status of Claim (Header)
FROM-DOS-TO DOS	The from and thru dates of service
DIAG DISC	Number of days prescription to be taken
NDC	National Drug Code
DESC	The diagnosis description. If the diagnosis code billed is invalid, no description will print
NET-PD	The amount Medicaid paid for this claim
LINES 001-XXX	Breakdown of the Medicaid Claim into Line Items (Lines 001-004 in example).

c. Example - Claim Type: D (Dental)

REPORT: FR66200-R0010 PAYER: DHB	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS AS OF: 12/01/9999 RECIPIENT HISTORY PROFILE REPORT	PROCESS DATE: 12/01/9999 PROCESS TIME: 00:00:44 PAGE: 500
RECIPIENT (123456789L)	PROFILE PG- 325	
REQ BY CLERK=C999VOLD	REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNQRSTUUVWXYZ	DATES=03/01/9999-11/30/9999
BASE ID=004330736 GENDER=F NAME=RONA, COCO	HIC 0000000000E MBI	DOB=03/01/2020 DOD=
-----CLAIM-----	PROV NBR ATTN NBR PS ADM-FIN DTE AT AH DH	BILLED PAT-LIAB SPEND-DWN PAYABLE NET-PD
C TCN S B AUTHORIZATION	DIAG DESC DIAG DESC	DIAG DESC
T FIN PAYER T R D-----	T ST FROM-DATE-TO PL QTY PROC TOOTH NBR SURFSRV IM EOB BILLED REIM CO-PAY OTH-INS PAID	
	L PGP PAC MODIFIERS DESC PCT	
D 11112233330000 P N	032199 290.00	.00 .00 125.28 125.28
BILLING NPI 0000044499 BILL TXNMY 1111G0003X	ATTN NPI 9990004444 ATTN TXNMY 1111G8888X	
DHB CK= EL.DAYS		ICD VER ICD VER
001 P MCAID 2	032199 032199 11 1.000 D1111 00 DENTAL PROPHYLAXIS ADULT	N@4 95.00 36.21 3.00 .00 33.21 .0000 COS=2222
002 P MCAID 4	032199 032199 11 1.000 D0110 00 PERIODIC ORAL EVALUATION	N@4 55.00 24.51 .00 .00 24.51 .0000 COS=
003 P MCAID 2	032199 032199 11 1.000 D2222 00 BITEWINGS FOUR IMAGES	N@4 64.00 30.50 .00 .00 30.50 .0000 COS=
004 P MCAID 2	032199 032199 11 1.000 D0220 00 INTRAORAL PERIAPICAL FIRST	N@4 28.00 14.18 .00 .00 14.18 .0000 COS=
005 P MCAID 2	032199 032199 11 1.000 D5555 00 INTRAORAL PERIAPICAL EA ADD	N@4 24.00 11.44 .00 .00 11.44 .0000 COS=
006 P MCAID 2	032199 032199 11 1.000 D5555 00 INTRAORAL PERIAPICAL EA ADD	N@4 24.00 11.44 .00 .00 11.44 .0000 COS=

C T	Claim type (Header)
S T	Status of Claim (Header)
FROM-DATE-TO	From Date of Services to Date of Service
DIAG DISC	The diagnosis description. If the diagnosis code billed is invalid, no description will print
TOOTH NBR	Indicates removal of teeth.
NET-PD	The amount Medicaid paid for this claim
LINES 001-XXX	Breakdown of the Medicaid Claim into Line Items (Lines 001-004 in example).

d. Example - Claim Type: O (Outpatient)

REPORT: FR66200-R0010 PAYER: DHB	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS AS OF: 12/01/9999 RECIPIENT HISTORY PROFILE REPORT	PROCESS DATE: 12/01/9999 PROCESS TIME: 00:00:44 PAGE: 500					
RECIPIENT (123456789L) PROFILE PG- 65							
REQ BY CLERK=C999VOLD REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIKLMNOPQRSTUVWXYZ DATES=03/01/9999-11/30/9999							
BASE ID=004330736 GENDER=F NAME=RONA, COCO HIC 0000000000E MBI DOB=03/01/2020 DOD=							
-----CLAIM----- C TCN S B T FIN PAYER T R D	PROV NBR ATTN NBR AUTHORIZATION D	PS ADM-FIN DTE AT AH DH DIAG DESC DIAG DESC	BILLED DIAG DESC	PAT-LIAB SPEND-DWN	PAYABLE	NET-PD	
	T ST FROM-DATE-TO PL QTY PROC TOOTH NBR SURFSRV IM EOB L PGP PAC MODIFIERS DESC		BILLED PCT	REIM	CO-PAY	OTH-INS	PAID
O 233332222202222	P N BILLING NPI 9999999999 BILL TXNMY 222N00000X	07 040499 1 ATTN NPI ATTN TXNMY	1884.38	.00	.00	312.03	312.03
CK=000000089 EL DAYS	O777770	MATERNAL CARE FOR Z5A90 9 WEEKS GESTATION					ICD VER 0 ICD VER
MCRD=M000000444	PCP=	PI= ADMIT DIAG	COV= 0	NONCOV= 0			
001 P MCAID	040499 040499	22 1.000 0300 00 N@3 LAB-GEN CLASSIFICATION	102.47 .0000 COS=0050	14.51	.00	.00	14.51
002 P MCAID	040499 040499	22 1.000 0500 00 N@3 LAB-GEN CLASSIFICATION	61.07 .0000 COS=0050	3.71	.00	.00	3.71
003 P MCAID	040499 040499	22 1.000 0500 00 N@3 LAB-GEN CLASSIFICATION	46.58 .0000 COS=0050	3.71	.00	.00	3.71
004 P MCAID	040499 040499	22 1.000 0500 00 N@3 LAB-GEN CLASSIFICATION	32.09 .0000 COS=0050	2.72	.00	.00	2.72
005 P MCAID	040499 040499	22 1.000 0402 00 N@B OTHER IMAGING SER-ULTRASOUND	330.17 .0000 COS=0050	.00	.00	.00	57.78
006 P MCAID	040499 040499	22 1.000 0450 00 N@B EMERGENCY ROOM-GEN CLAS S	1312.00 .0000 COS=0050	.00	.00	.00	229.60

C T	Claim Type (Header)
S T	Status of Claim (Header)
DESC	The diagnosis description. If the diagnosis code billed is invalid, no description will print
FROM-DATE-TO	The from and to dates of service
NET PAID	The amount Medicaid paid for this claim
LINES 001-XXX	Breakdown of the Medicaid Claim into Line Items (Lines 001-004 in example).

e. Example - Claim Type: FPP (Family Planning)

REPORT: FR66200-R0010 PAYER: DHB	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS AS OF: 12/01/9999 RECIPIENT HISTORY PROFILE REPORT	PROCESS DATE: 12/01/9999 PROCESS TIME: 00:00:44 PAGE: 500						
RECIPIENT (123456789L)	PROFILE PG- 65							
REQ BY CLERK=C999VOLD	REQ FOR PROV= ALL CLAIM TYPE = 012345689ABCDEFGHIJKLMNOPQRSTUVWXYZ	DATES=03/01/9999-11/30/9999						
BASE ID=004330736 GENDER=F NAME=RONA, COCO	HIC 0000000000E MBI	DOB=03/01/2020 DOD=						
-----CLAIM-----	PROV NBR	ATTN NBR	PS ADM-FIN DTE AT AH DH	BILLED	PAT-LIAB	SPEND-DWN	PAYABLE	NET-PD
C TCN	S B AUTHORIZATION	DIAG DESC	DIAG DESC	DIAG DESC				
T FIN PAYER	T R D-----							
	T ST FROM-DATE-TO PL QTY PROC TOOTH NBR SURFSRV IM	EOB BILLED	REIM	CO-PAY	OTH-INS		PAID	
	L PGP PAC MODIFIERS	DESC	PCT					
C 1111222000440000 P N	040799		225.00	.00	.00	152.82		152.82
	BILLING NPI 1222777555 BILL TXNMY 666QP5555X	ATTN NPI 0009998877	ATTN TXNMY 569A00000X					
DHB CK=	Z3009	ENCOUNTER FOR OTH Z3333	ENCOUNTER FOR PREG Z333	ENCNTR SCREEN FOR				ICD VER 0
EL DAYS								ICD VER
MCRD=999333	PCP=	PI=	ADMIT DIAG	COV= 0	NONCOV= 0			
001 P	040799 040799	73	1.000 98989 00 N@3	190.00	142.00	.00	.00	142.00
MCAID 2	FP		PREV VISIT EST AGE 18-39	.0000	COS=2110			
002 P	040799 040799	73	1.000 55555 00 N@3	15.00	2.78	.00	.00	2.78
MCAID 4	FP		ROUTINE VENIPUNCTURE	.0000	COS=			
003 P	040799 040799	73	1.000 88888 00 N@3	20.00	8.04	.00	.00	8.04
MCAID 4	FP		PREGNANCY TEST	.0000	COS=			

C	Claim Type (Header)
T	
S	Status of Claim (Header)
T	
NET-PD	The amount Medicaid paid for this claim
FP	Family Planning Modifier

XIX. CITATIONS AND REFERENCES

Social Security Act, Title XIX, Section 1909

42 CFR 455 "Program Integrity"

Social Security Act 1137, 4359.40ff

IRS Code of 1954, Section 6103(l)

44 CFR 17926 (March 23, 1979) amended at 51 CFR 7178 (February 8, 1986, effective May 29, 1986)

Social Security Act, Title 1902(a)(7)

42 CFR 431.301-305

Privacy Act of 1947 (PL 93-579), Section 552(b) (7)

10 NCAC 26G

10 NCAC 26G.08

10 NCAC 24B .0306

20 NCAC 32S .0306

NCGS 7B-601 and 7B-110B

NCGS 108A-64

NCGS 108A-80, 143B-153

NCGS 14-100

Title 11 of the United States Code

NCGS 105A-8

NCGS 105A-12