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**CORRECTIVE ACTION AND RESPONSIBILITY FOR ERRORS**

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**MA-2395 CORRECTIVE ACTION AND RESPONSIBILITY FOR ERRORS**

REVISED 10/01/10 - CHANGE NO. 14-10

**I. BACKGROUND**

Nearly 65% of Medicaid program service costs come from federal funds. The Centers for Medicare and Medicaid Services (CMS) prescribes limits on the use of federal funds provided to states for Medicaid expenditures and time limits for claiming federal financial participation (FFP). State expenditures under the Medicaid program are audited continuously by CMS financial staff and by onsite state auditors. Selective audits may be performed by the U.S. Office of the Inspector General and the General Accounting Office.

This section provides instructions for retroactive authorizations or changes to correct prior actions to assure that an applicant/beneficiary (a/b) receives accurate benefits and that federal funds are claimed appropriately.

**II. REQUIREMENTS**

**A. The Division of Medical Assistance (DMA) is responsible for making corrections in the following:**

1. Terminated Cases

There is verified information that a terminated case has errors in:

- a. Medicaid eligibility segments,
- b. Buy-in effective date,
- c. Eligible case members,
- d. Community Alternatives Programs (CAP) indicators and effective dates,  
or
- e. Other beneficiary data that causes valid claims to deny.

2. Active Cases

It is necessary to change an active case to:

- a. Correct keying errors,
- b. Reduce a pml in a long-term care (ltc) case (see MA-2270, VI.I.),

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(II.A.2.)

- c. Post CAP, or other indicator codes,
- d. Correct eligibility segments, or
- e. Correct other data which affects the payment of claims.

3. Wrong County

When eligibility was authorized in the wrong county in cases of county transfers or incorrect EIS input or when the SDX shows an SSI beneficiary in the wrong county. DMA will handle on a case-by-case basis in contact with the counties involved. See. III.B.2. and III.F., below.

4. County DSS Refuses to Take Corrective Action

The county dss refuses to take required corrective actions. DMA will handle on a case-by-case basis.

5. Audit

An audit shows verified errors in the Medicaid eligibility history or beneficiary ID number.

**B. County Corrective Actions**

1. General

a. Claims will be paid only for individuals with Medicaid authorization in the Eligibility Information System (EIS) for the date(s) a medical service(s) is provided.

- (1) A provider must file a claim for payment for a Medicaid covered service within 365 days of the date of service. However, eligibility for the date of service may not have been authorized in time to meet this deadline.
- (2) The county department of social services (dss) must request DMA to override the claims filing time limit if the time limit has expired. Refer to III.D., below, for procedures.

2. Incorrectly authorized dates:

- a. May not be deleted in a prior period, but
- b. May be deleted from a future period provided notice requirements are met.

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(II.B.)

3. Financial responsibility for incorrect authorization must be borne by:
  - a. The county dss which took the incorrect action (see IV.C., below), or
  - b. The state, if state error was the sole cause of the incorrect action. See IV.D., below.
4. The county dss must make a correction when:
  - a. An individual was:
    - (1) Discouraged from applying for assistance, or
    - (2) Improperly encouraged to withdraw an application for assistance,
  - b. An individual's application for assistance was denied improperly,
  - c. An appeal, court decision, or a Social Security Administration (SSA) reversal overturns an earlier adverse decision,
  - d. Certification periods of financially responsible persons must be adjusted,
  - e. It receives from any source verified information which changes a beneficiaries:
    - (1) Deductible amount,
    - (2) Patient monthly liability (pml) amount,
    - (3) Period of authorization, or
    - (4) Eligibility status,
  - f. Additional medical bills or verified medical expenses establish an earlier Medicaid effective date in deductible cases (see MA-2360, Medicaid Deductible, for procedures),
  - g. An SSI beneficiary enters long-term care (ltc) or a Community Alternatives Program (CAP),
  - h. The county dss makes an administrative error. Correction of administrative error by the county dss is limited to:
    - (1) Cases terminated or denied in error,
    - (2) Failure to act properly on information received which would affect eligibility,

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(II.B.4.h.)

- (3) Incorrect determinations of:
  - (a) The period of authorization, or
  - (b) The Medicaid effective date,
- (4) Erroneous data entry, or
- (5) M-AD denial which:
  - (a) Was an adoption of an SSA denial, and
  - (b) SSA subsequently approves the disability without an appeal or reconsideration hearing (see MA-2525, V.C.), and
  - (c) The onset of disability is prior to the date of the denial of the adopted decision.
- 5. The county dss may learn of a change in an SSI/SDX case that affects the beneficiaries eligibility and the beneficiary either does not or cannot report the change to SSA. Refer to III.B.2.c., below, for procedures.
- 6. Correcting eligibility to the beneficiaries advantage must be made immediately after discovery of the error.
  - a. Adverse actions must be made only after appropriate notice requirements are met.
  - b. All actions must be completed at least within 30 days of discovery of the error.
- 7. Time Limits for Making Corrections

Reopen the case back to the original action. Refer to MA-2304, Processing the Application, section IV.B for procedures regarding time limits for reopening a Medicaid case.

  - a. when the original determination of eligibility is reversed because of a county or state appeal decision or a court ruling in favor of the a/b, or
  - b. For a denied Medical Assistance for the Disabled (M-AD) case:
    - (1) The previous Medicaid denial of a disability application was an adoption of a denial by SSA, and RSDI or SSI was subsequently approved on appeal to SSA.

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(II.B.7.b.)

- (2) The onset of disability corresponds to or is prior to the date of the denial of the adopted decision (see MA-2525, Disability)for procedures.
  
- c. Either the county dss discovers or monitoring establishes that there was:
  - (1) Discouragement from applying for assistance,
  - (2) Improper withdrawal of an application, or
  - (3) Improper denial of an application.
  
- 8. Authorize eligibility for no more than 12 months prior to the month it discovered the need for corrective action when:
  - a. It receives from any source verified information which changes a beneficiaries:
    - (1) Deductible amount,
    - (2) Patient monthly liability amount,
    - (3) Period of authorization, or
    - (4) Eligibility status,
  
  - b. Additional medical bills or verified medical expenses establish an earlier Medicaid effective date in deductible cases (see MA-2360, Medicaid Deductible, for procedures), or
  
  - c. The county dss makes an administrative error. Correction of administrative error by the county dss is limited to:
    - (1) Cases terminated or denied in error, or
    - (2) Failure to act properly on information received which would affect eligibility, or
    - (3) Incorrect determinations of:
      - (a) The period of authorization, or
      - (b) The Medicaid effective date,

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(II.B.8.c.)

- (4) Erroneous data entry, or
- (5) M-AD denial which:
  - (a) Was an adoption of an SSA denial, and
  - (b) SSA subsequently approves the disability without an appeal or reconsideration hearing (see MA-2525, V.C.), and
  - (c) The onset of disability is prior to the date of the denial of the adopted decision.
9. Reopening and corrective action must be completed no later than 30 days after the county dss learns of any of the conditions in B.4., above, unless good cause exists or policy otherwise states to reopen within 5 days. Good cause is limited to:
  - a. The need to verify other conditions of eligibility before authorizing eligibility,
  - b. Inability to locate the a/b, or
  - c. Timely request for administrative review by DMA when the county dss disagrees with a decision requiring corrective action.

**C. Override of the Claims Filing Time Limit**

1. Medical providers must file claims for payment by Medicaid within 365 days of the date of service.
2. DMA has limited authority under federal regulations to override or waive the time limit for filing claims and be able to claim the federal share of the payment.
3. DMA is not authorized to use state funds in place of federal funds which cannot be claimed because of delays in timely claims filing. Therefore, attention to the claims filing time limit and notification to DMA of the need to override the time limit in the case of corrective action is critical. Failure of the county dss to notify DMA of the need for an override as specified in this section may result in full financial responsibility for payment of the Medicaid claims by the county dss.
4. If an enrolled Medicaid provider is unable to file claims for reimbursement for services to a Medicaid beneficiary for reasons beyond the provider's control, such as retroactive approval of eligibility in a case, and there is basis for an override as described in 7., below, the county dss must request an override of the time limit for filing claims.

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(II.C.)

5. A request for an override of the claims filing time limit may be necessary if:
  - a. The 365 day time limit for filing claims has expired, or
  - b. Less than 60 days remain before the 365 day time limit expires, and
  - c. Eligibility has been entered into EIS.
6. The request for override of the claims filing time limit must be submitted to DMA by the county dss at the time of disposition of the application in EIS or entry of the corrective action into EIS.
7. The request for an override must meet at least one of the following conditions:
  - a. Subsequent reversal by SSA of a prior RSDI/SSI disability denial which was adopted for a Medicaid application. Authorization may be from date of onset of disability or 3 months retroactive to the month of the original Medicaid application, whichever is later.
  - b. Subsequent approval by SSA of an RSDI/SSI disability application that was not adopted by Medicaid and is not the result of a reconsideration/appeal. Authorization is limited to 12 months prior to learning of the subsequent RSDI/SSI disability approval.
  - c. Subsequent approval by SSA of an SSI Medicaid application which required more than 365 days to process. Approval of an SSI reversal cannot be prior to 01-01-95.
  - d. Approval by SSA of an SSI application for an individual who has not made a Medicaid application at the county dss and the beginning date of eligibility does not allow medical providers at least 60 calendar days in which to file Medicaid claims. Approval of an SSI Medicaid case cannot be prior to 01-01-95.
  - e. County or state appeal decision in favor of the a/b.
  - f. Court order in favor of the a/b.
  - g. County administrative error.
  - h. The a/b was discouraged from applying for assistance, encouraged to withdraw an application for assistance, or an application for assistance was improperly denied.
  - i. The county dss learns of a change in an SSI/SDX case that affects the beneficiaries eligibility and the beneficiary either does not or cannot report the change to SSA. See III.B.2., below.

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(II.C.)

8. The county dss must ensure that correction of an error complies with policy before requesting an override, that is, eligibility for the period in question has been determined properly and entered into EIS. See B.4., above.
9. Authorization of eligibility that is inconsistent with state policy will result in full financial responsibility (federal, state, and county shares) for total payment of the claims by the county dss. See IV.C., below.
10. Requesting an override, refer to III. D.

**III. PROCEDURES**

**A. Reopening an Application**

1. Reopen the application back to the earliest date allowed for the type of reopen, and
2. Determine eligibility for each subsequent period to the present.
3. Follow instructions in MA-2304, Processing The Application, MA-2525, Disability, and the EIS Manual for reopening applications and establishing certification periods (c.p.).

**B. Correcting a Case**

1. Make the correction as soon as an error is discovered and request an override of the claims filing time limit if necessary. The process must be completed promptly but no more than 30 days after discovery of the error.
2. When the county dss learns of a change in an SSI/SDX case that affects the beneficiary's eligibility and the beneficiary either does not or cannot report the change to SSA, the IMC must:
  - a. Follow instructions in MA-1000, SSI Medicaid: Automated Process, and
  - b. Use DMA-5049, Referral to the Local Social Security Office, to report the information.
  - c. The following are examples of situations which may affect the beneficiaries SSI and Medicaid eligibility:
    - (1) Discrepancy in date of birth,
    - (2) Beneficiaries death,

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(III.B.2.c.)

- (3) Beneficiary enters a public institution, nursing facility, or adult care home (rest home),
- (4) SSA has the beneficiary assigned to the wrong county because of mail route numbers or other factors,
- (5) Any information that affects the SSI payment, or
- (6) DSS suspects fraud.

**C. Entering Eligibility in EIS**

Enter correct eligibility in EIS and the case record at the time of approval of a case/individual retroactively:

- 1. If a case is active in EIS, enter eligibility according to EIS instructions.
- 2. If the case is not active, reopen it following policy for the type of action taken and dispose of it according to EIS instructions.

**D. Requesting An Override**

Submit a request for approval of an override if the 365 day time limit has expired:

- 1. Request an override using [DMA-5170, Request for Claims Override](#), for all cases at the time of disposition/correction of an error and entering of changes into EIS. See II.C.4. and 5., above.
- 2. For ALL override requests include the following:
  - a. Date of application,
  - b. Date of disposition,
  - c. Beneficiary name and individual Medicaid identification number (MID),
  - d. Reason for override request. Refer to II.C.7., above, for acceptable reasons for overrides. There are NO OTHER acceptable reasons for an override. DO NOT ADD any other reason(s) to the request.
  - e. Eligible dates for which an override is needed as entered in EIS, so that claims submitted by providers who served the individual on eligible dates of service can be paid.
  - f. Name and address of person to whom the override approval letter is to be sent.

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(III.D.)

3. For disability reversal cases include:
  - a. All items listed in 2., above, and
  - b. Date county dss received notice of the disability reversal, and
  - c. Date of onset of disability.
4. For appeal reversals and court decisions include:
  - a. All items listed in 2., above, and
  - b. The date the county dss received DSS-1894, "Notice of Decision," or court decision, for appeal reversal and court decision override requests.
  - c. Eligibility for appeals or court decisions is not restricted to the 365 days preceding the "Notice of Decision" or court order.
5. For cases involving administrative error include:
  - a. All items listed in 2., above, and
  - b. The reason an override is needed:
    - (1) Information acted on improperly,
    - (2) Case was denied or terminated in error,
    - (3) Period authorized was incorrect or erroneously omitted from EIS, or
    - (4) County dss failed to act on the case.
  - c. Date error was discovered.
  - d. Do not authorize eligible dates for more than the 12 months period before the month dss discovers the error.

**EXAMPLE:** An error discovered on March 12th must be corrected and the override request sent to DMA no later than April 11th. If the override is for administrative error, it cannot be approved for any month prior to March of the previous year.

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(III.D.)

6. Submit override requests to:

Division of Medical Assistance

Claims Analysis Unit

2501 Mail Service Center

Raleigh, NC 27699-2501

7. Approval of Override Request

a. If the override request is approved, the DMA Claims Analysis Unit will notify:

(1) The county dss of its decision by the turnaround of the override letter [DMA-5170, Request for Claims Override](#), and

(2) The beneficiary by letter [DMA-5171, Approval Notice of Retroactive Medicaid Benefits](#), instructing him to inform medical providers that they may file claims for services provided during eligible dates.

b. The county dss must notify medical providers of the override approval:

(1) If the beneficiary is deceased or mentally or physically unable to act on his own behalf,

(2) Has no responsible person to act on his behalf, or

(3) If the county has guardianship.

c. Providers must file all claims by the date specified on the beneficiary's override approval letter. They may submit claims by electronic transmission or paper to HP (formerly EDS), the Medicaid contractor at:

HP

P.O. Box 30968

Raleigh, NC 27622

8. Denial of Override Request

If the override request is denied, the DMA Claims Analysis Unit will:

a. Notify the county dss of its decision by the turnaround of the override letter [DMA-5170, Request for Claims Override](#), and

b. Inform the county dss that claims requiring special handling will be charged to the county.

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(III.)

E. Erroneous Authorization

1. When a keying error results in erroneous authorization of Medicaid benefits for an individual who is not eligible or for dates an individual is not eligible the IMC must:
  - a. Telephone the Claims Analysis Unit at DMA (919/855-4045) as soon as the error is discovered to request that the authorization be corrected.
  - b. Contact the beneficiary to inform him of the error. Ask him not to use the Medicaid ID card if one has been issued.
  - c. Ask the beneficiary to identify any medical providers who were seen in the period covered by the erroneous authorization.
  - d. Contact all medical providers seen on the ineligible dates:
    - (1) Inform them of the error, and
    - (2) Advise them that the a/b is not eligible for services in that period and that services rendered are not eligible for payment, and
    - (3) Advise them not to file claims for erroneously approved date(s)/ineligible person(s), and
    - (4) Inform them that the eligibility file is being corrected.
  - e. Follow up within 10 workdays with a letter to the DMA Claims Analysis Unit.
    - (1) **Identify all providers contacted.**
    - (2) Attach documentation of the error (i.e., screen print copy of the IE screen showing the error and forms/documents giving the correct authorization dates), and
    - (3) Give a brief explanation of the cause of the error. See [DMA-5172, Erroneous Authorization Dates of Medicaid Eligibility](#), for a sample letter, including documentation of providers contacted with date(s) of contact.

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(III.E.1.)

- g. Documentation will be retained by DMA for audit purposes.
- 2. When claims are paid for ineligible date(s)/persons(s):
  - a. If providers were notified prior to billing, the claims will be recouped from the provider.
  - b. If providers were not notified prior to billing, the claims are county responsible and are subject to county charge back procedures.
- 3. When any notice of authorization or letter of approval is issued with incorrect dates and the county dss discovers the error before anything is keyed into EIS, dss may send a corrected notice or letter within 2 workdays of discovering the error. Otherwise, the county dss will bear full financial responsibility (federal, state, and county share) for any claims.

F. Corrections to Errors in County Transfers/Reassignments

1. County Actions

- a. A county dss which receives a profile on a case which was incorrectly transferred or reassigned to a different county must:
  - (1) Contact the original county to determine the county to which the case should have been transferred or reassigned.
  - (2) Reassign the case to the correct county.
  - (3) Write the Claims Analysis Unit at the address in D.6., above, to inform them of the circumstances of the case and request correction of county liability for claims, clearly stating which county has responsibility for dates of authorization to be corrected.
- b. If a county dss discovers that the SDX has an SSI beneficiary in the wrong county that county dss must correct the information as instructed in MA-1000 and in II.B.5., above.

2. DMA Actions

The Claims Analysis Unit will make the necessary corrections in EIS.

3. Additional Instructions

Refer to EIS 1200.

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**IV. FINANCIAL RESPONSIBILITY**

- A. When an error results in the issuance of incorrect benefits, the county dss or the state may have to assume full financial responsibility for the erroneous benefits, because FFP is not available for payment of claims for ineligible individuals.
- B. Claims will be paid to a medical provider who in good faith renders services to an individual who:
1. Presents a valid Medicaid ID card for the date(s) of service or to whom a DMA-5016 or DMA-5020 has been issued, or
  2. Is authorized in EIS on the date(s) of service and the provider verified eligibility through the eligibility verification system, but eligibility is deleted after provider verification and prior to filing the claim(s).

C. County DSS Responsibility

The county dss will bear full financial responsibility (federal, state, and county shares) for payment of Medicaid claims resulting from erroneous issuance of benefits when dss takes any one of the following actions:

1. Fails to issue timely or incorrectly issues a DMA-5016/5020 to medical providers informing an individual of a pml or a deductible balance,
2. Fails to issue a corrected notice of approval within 10 work days after the original notice was issued,
3. Fails to enter ending dates in EIS for special coverage under CAP or Carolina Access,
4. Enters in EIS an authorization date which is earlier than the correct date of eligibility,
5. Terminates a case or individual after the Medicaid ID card has been issued,
6. Fails to determine availability or to enter in EIS information regarding third party resources (refer to MA-2400, Third Party Recovery),
7. Fails to inform the Third Party Recovery Section of DMA when it is aware that an a/b has been involved in an accident where there was a third party resource and failure to make the information known results in the state's being unable to recoup Medicaid expenditures,

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(IV.C.)

8. Gives a beneficiary a county-issued Medicaid identification card indicating authorization for dates for which the beneficiary is ineligible,
9. Fails to apply for Medicare Part B coverage for eligible persons who are deceased or are physically or mentally unable to apply and have no responsible person to apply on their behalf, or for whom the county dss has guardianship (refer to MA-2410, Medicare Enrollment & Buy In, VIII.C. D. and E.) or
10. Provides erroneous information to an a/b or takes or fails to take an action which requires payment of Medicaid claims for
  - a. An ineligible individual,
  - b. Ineligible dates,
  - c. An amount for which the beneficiary is responsible and for which the state cannot claim FFP,
  - d. County authorized eligibility for administrative error for a period over 12 months prior to discovery of the error in an ongoing case or disposition of an application, or
11. Fails to request an override and correct an error in eligibility within at least 30 days of discovery of an error in an ongoing or terminated case if an override of the claims filing time limit is needed and as a result FFP cannot be claimed. See II.B.4. and II.C.4., above.
12. Fails to request an override at the time of disposition of an application if an override of the claims filing time limit is needed and as a result FFP cannot be claimed. See II.B.4., above.

**D. State Responsibility**

1. DMA will bear full financial responsibility (federal, state, and county share) for payment of Medicaid claims resulting from erroneous issuance of benefits when:
  - a. DMA staff issues an incorrect interpretation of policy in the Medicaid eligibility manual(s) and that interpretation is the sole cause of an erroneous benefit or payment,
  - b. Medicaid identification cards are mailed because state staff failed to remove cards from outgoing mail subsequent to the timely termination or reduction in benefits by county dss staff.

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(IV.D.1.)

- c. A system failure in the state computer center occurs on the last cutoff date of the month, preventing data entry of terminations or other adverse actions by the county dss,
  - d. Other errors occur which are the sole responsibility of the state office.
2. DMA will recoup from provider(s) any claims paid for ineligible date(s) of service or ineligible individual(s) if the county dss notified providers prior to billing that the individual was not eligible and the provider filed claims.
  3. DMA will notify the county dss by letter if there is to be a charge back.
  4. The county dss is entitled to a review if it does not agree with any charge back action taken by DMA. It must request a review in writing and include all necessary documentation to support the county's actions within 30 days of the action.
  5. Send requests for reviews to:  
  
Division of Medical Assistance  
  
Claims Analysis Unit  
  
2501 Mail Service Center  
  
Raleigh, NC 27699-2501