

DEPARTMENT OF HEALTH SERVICES

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May 24, 1990

To: All County Welfare Directors
All County Administrative Officers

Letter No. 90-47

SUBJECT: MODIFICATION OF THE ASSET MATCH OVERPAYMENT REFERRAL PROCEDURE

The purpose of this letter is to inform you of a modification to the Income and Eligibility Verification System (IEVS) asset match overpayment process. The modification will reduce the workload associated with processing the asset match overpayment by providing Medi-Cal usage data for the last 36 months at the bottom of the asset match abstract. This information will assist a county in determining if an asset based overpayment exists and if there is a need to develop an overpayment referral to the Department of Health Services (DHS) Audits and Investigations (A&I) Division.

The yearly asset match is usually sent to counties in February; however this year the match has been delayed so Medi-Cal usage information could be included. It is anticipated that the Medi-Cal usage information will be sent to counties for processing, with the asset match, by the end of May 1990.

Background:

The current asset match overpayment referral process is detailed in All County Welfare Directors Letter (ACWDL) 89-24. Under this process, an Eligibility Worker (EW) must review the IEVS asset abstract upon receipt to determine if the asset information was declared. If it is determined that the asset was undeclared and a potential overpayment of \$100 or more exists, a referral must be sent to the appropriate DHS Investigations field office. If the county determines there is no impact on eligibility, no referral is required.

In the past, when a county made an overpayment referral, there was no access to Medi-Cal usage information or knowledge of whether usage occurred during the period of eligibility. As a result, counties were required to make referrals to the DHS on many cases which ultimately had little or no Medi-Cal usage. It is estimated that 30% of all asset match referrals could have been avoided had usage information been available.

Modified Overpayment Procedure:

The modified overpayment procedure will reduce the county workload by providing information which allows counties to determine if Medi-Cal usage occurred for the period in question, prior to referring the case to DHS.

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Under the modified procedure, Medi-Cal usage data is obtained from the Claims Detail Report (CDR) and will be summarized at the bottom of the asset match abstract. Currently, the CDR information is unavailable for inclusion on the Earnings Clearance System/Integrated Fraud Detection System (IFD) match. There are plans underway to include the CDR information on future IFD matches.

Enclosed, is an example of how the summarized Medi-Cal usage data will look on the asset abstract. The abstract displays the monthly amount of Medi-Cal usage for the previous 36 months and the total claims paid for that period. If total usage is over \$100 for the months of potential ineligibility, an overpayment referral is required. If total usage is under \$100, no referral is required. Remember, if a decision is made to refer an overpayment, follow the referral procedures detailed in ACWDL 89-24 (released June 9, 1989). The IEVS Bulletin 89-7 (released August 30, 1989) is also helpful in developing an overpayment package. The bulletin answers the most frequently asked questions on how to make an overpayment referral.

Reviewing Cases Not Processed Through The CDR System:

There are several State programs that do not process their claims through the CDR system; therefore, services provided by these programs can not be identified using the CDR. These programs are as follows:

- Child Health and Disability Prevention
- Delta Dental
- Prepaid Health Plans
- Redwood Health (Lake, Mendicino, and Sonoma)
- San Mateo Initiative
- Santa Barbara Initiative
- State Hospitals
- Short Doyle

If it is suspected a recipient was enrolled or received services from any of the above programs and an overpayment of \$100 or more is suspected, the EW should consider reviewing the case file and the Medi-Cal Eligibility Data System (MEDS). If it is confirmed that medical services were rendered or capitation occurred in any of the months the recipient was or may have been ineligible, an overpayment referral is required. Remember, if a decision is made to refer an overpayment, follow the procedures detailed in ACWDL 89-24.

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If you have any questions regarding the information contained in this letter,
please contact Ross Farmer of my staff at (916) 322-3394.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures 

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants
IEVS Coordinators