



COMBINED MEDICAID 1504-1 Over and Under Issuance

Supersedes: FMA 1504-1 (07/01/08), MA 1504-1 (07/01/08)

Reference: 42 U.S.C. 1396b(u) and 1396p(a); 42 CFR 431.210, .211, .213 and .214; 42 CFR 433.36(g)(1); 53-2-108, MCA; ARM 37.82.101, .207; ARM 37.5.505

Overview: Over issuance claims are established for all client-caused Medicaid eligibility errors, whether inadvertent or intentional on the client's part. Over issuance claims are not established for agency-caused (administrative) Medicaid eligibility errors. Claims are also not established when the over issuance is due to the client receiving an SSI payment in error.

Over issuance claims are established for continued benefits received pending a fair hearing when the hearing decision supports the agency action. Patient liability for nursing home coverage can only be changed prospectively; adequate notice must be given. A Medicaid over issuance is established for past months' patient liability, if the incorrect liability was due to a client-error.

DETERMINING OVERISSUANCE AMOUNT:

The over issuance amount for each benefit month is the smaller of the:

1. total Medicaid benefits paid on the ineligible client's behalf, OR
2. difference between the amount of an accurately calculated monthly spend down and the amount of monthly spend down the client paid toward an incorrectly calculated spend down.

SETTLEMENTS:

TPL pursues Medicaid repayment when a Medicaid client receives a settlement to reimburse their medical expenses caused by an accident or injury (i.e., auto insurance or workers' comp settlement).

UNDERISSUANCE:

When information discovered/received results in an under issuance (i.e., lower cash option amount or earlier eligibility date), the under issuance business process is followed.

Effective Date: July 01, 2016