

RE: MEDICAID REVIEW

Dear _____:

This is to confirm the telephone conversation of _____, at which time _____ discussed with you the beginning of a Medicaid review, by our office, of the Patient Personal Needs Account, and deductions from recurring income for non-covered medical expenses. The purpose of this review is to determine if these programs are being administered in accordance with the provisions of applicable Federal and State laws and regulations, and the contract entered into between _____ and the Department of Health and Human Services.

_____, along with _____ members of our staff, will start the review on _____ at _____ a.m. We would appreciate very much your making available adequate working space for our staff as well as access to the following records:

1. Medicaid Remittance Advices for the period _____ to _____.
2. Fund bank statements for the past 12 months.
3. All Personal needs fund records including any burial or savings accounts and supporting vouchers for all patients in the facility.
4. Current monthly census report.
5. Fidelity bonds for personnel involved in the maintenance of personal needs funds accounts.
6. Log of Incurred Medical Expenses for the period _____ to _____ and related vendor bills.
7. Access to patients' medical records.

Our auditors look forward to working with your staff to accomplish our objectives with a minimum of disruption to your normal operations.

Should you have any questions, please contact _____ at our Office.

Yours very truly,

Audit Manager

___/___

RE: AC# 3-_____ (PN) - _____

Dear _____:

A review of the Patients' Personal Needs Account (PNA) and deductions claimed for non-covered medical expenses was conducted, by our office on _____, and included tests for compliance with applicable state and federal laws and regulations, and the administrative guidelines as set forth in the contract between _____ and the Department of Health and Human Services. As a result of this review, we noted the following:

Patients' Personal Needs Account

Deductions For Non-Covered Medical Expenses

By request of the state medicaid agency this letter also serves as an official notice of your requirement to respond with a report of planned corrective actions on the recommendations and deficiencies noted in this report within forty-five (45) days of the date of this letter. Your response should reference the audit control number and be addressed to: Division of Home Health and Nursing Facility Services Department of Health and Human Services, Post Office Box 8206, Columbia, South Carolina 29202-8206. You are also required to simultaneously furnish a copy of your corrective action report to the State Auditor's Office.

Sincerely,

Edgar A. Vaughn, Jr., CPA
State Auditor

cc: Ms. Mary S. Barnett

SOUTH CAROLINA STATE AUDITOR'S OFFICE
NURSING HOME AGREED UPON PROCEDURES

PROVIDER	WORK AREA	PERIOD
----------	-----------	--------

Personal Needs Funds		
Description	Done By and Date	W/P Reference

GENERAL:

1. The Purpose of the review of the Personal Needs Fund is to insure that they are administered in accordance with the applicable regulations, not to express an opinion or conclusion on the account balance, therefore audit sampling does not apply.

OBJECTIVES:

The objectives of this Program are:

1. To determine that the Provider has administered the personal needs funds of Medicaid recipients in accordance with the provisions of applicable federal and state laws and regulations, and the Contract entered into between the Provider and the DH&HS. Materiality is not relevant.
2. To ensure the Provider has in force a valid fidelity bond from a commercial surety company covering all officers, employees, servants, and agents of the Provider authorized to handle or be responsible for recipient funds.

SCOPE:

PROCEDURES:

1. **General**
 - a. Obtain a copy of the most recent Medicaid Remittance Advice.
 - b. Obtain the personal needs fund records including any burial or savings accounts noted and the supporting vouchers for all patients in the facility.
 - c. Verify that the patient's personal needs fund accounts are being kept in a separate bank account and are not commingled with the nursing home operation funds.
 - d. Review the prior working papers.

SOUTH CAROLINA STATE AUDITOR'S OFFICE
NURSING HOME AGREED UPON PROCEDURES

PROVIDER	WORK AREA	PERIOD
Personal Needs Funds		
Description	Done By and Date	W/P Reference

2. Personal Needs Account Balance

- a. Perform a proof of cash for the last month for which a bank statement has been received.
- b. Reconcile the Personal Needs Fund subsidiary ledgers to date, with the proof of cash. If petty cash for personal needs is maintained, it should be counted as part of the reconciliation.
- c. Review the bank statements of the past 12 months and determine the nature of unusual withdrawals or major changes in the pattern of routine deposits.
- d. Determine that the method of handling interest is consistent with the Provider's contract and current DH&HS guidelines.
- e. Verify that the patients total Personal Needs balances (general and savings) are within the SSI guidelines.

3. Test of Accounts

- a. Select accounts for current Medicaid patients for whom the Provider administers personal needs funds.
- b. Investigate the accounts for any open accounts with no current activity.
- c. Perform the following test for the accounts:
 - (1) Determine if the Provider has written authorization from patients to administer their personal needs accounts.
 - (2) Determine if the Provider gives patients quarterly financial statements.
 - (3) Analyze expenditures and receipts shown in personal needs accounts. Determine if expenditures were for items authorized to be purchased from those accounts by federal and state regulations.
 - (4) Ensure that all medically related expenditures (i.e. for wheelchairs) have been authorized by the patient's physician.

SOUTH CAROLINA STATE AUDITOR'S OFFICE
NURSING HOME AGREED UPON PROCEDURES

PROVIDER	WORK AREA	PERIOD
<u>Personal Needs Funds</u>		

Description	Done By and Date	W/P Reference
<p>(5) If disbursements are made to the patient's family, relatives or other persons, determine if the patients completely assents or the person receiving the funds have been appointed by Probate Court.</p> <p>(6) For Medicaid patients for whom the Provider does not administer the personal needs funds. Determine how their funds are handled.</p>		
<p>4. Test of Open Accounts for Former Patients</p> <p style="margin-left: 20px;">a. Compare the patient personal needs funds ledger cards with the current monthly census report and prepare a list of accounts still open for patients who are no longer at the facility.</p> <p style="margin-left: 20px;">b. Determine what has been done to dispose or attempt to dispose of these funds.</p>		
<p>5. Test of Disposition of Funds</p> <p style="margin-left: 20px;">a. Determine if there is a written plan regarding the disposal of open accounts for former patients.</p> <p style="margin-left: 20px;">b. Prepare a list of all parties deceased or discharged.</p> <p style="margin-left: 20px;">c. Determine what has been done to dispose of these funds.</p> <p style="margin-left: 20px;">d. Ensure that disposition of funds for deceased and discharged patients is accomplished pursuant to existing State Laws and Regulations.</p>		
<p>6. Determine that the Provider has obtained Fidelity bonds as required by contract for personnel involved in the maintenance of personal needs funds accounts.</p>		

FINDINGS/CONCLUSION:

SOUTH CAROLINA STATE AUDITOR'S OFFICE
NURSING HOME AGREED UPON PROCEDURES

PROVIDER	WORK AREA	PERIOD
----------	-----------	--------

Non-Covered Medical Expenses

<u>Description</u>	<u>Done By and Date</u>	<u>W/P Reference</u>
--------------------	-----------------------------	--------------------------

GENERAL:

The purpose of the review of the Non-covered Medical Expenses is to insure that they are administered in accordance with the applicable regulations, not to express an opinion or conclusion on the account balance, therefore audit sampling does not apply.

OBJECTIVES:

1. To determine if the facility has implemented procedures which allow deductions from monthly recurring income for patients who incur medical expenses not covered by Medicaid or another third party payer.
2. To determine if only allowable deductions for non-covered medical expenses were made from the patients' monthly recurring income.
3. To determine if any deductions received for non-covered medical expenses were properly documented and recorded.

SCOPE:

PROCEDURES:

1. Review Medicaid Bulletin NF 89-15 with Attachments I through III. Determine if the Provider has implemented the policy set forth in this Bulletin. If it has not been implemented, prepare a memorandum and PMLC and no further work will be required for this program.
2. Utilizing remittance advices for the contract period, select those deductions for non-covered medical charges made from recurring income.
 - a. For those items reviewed perform the following:
 - (1) If applicable, determine if prior approval by DH&HS was received (DH&HS Form 235).

SOUTH CAROLINA STATE AUDITOR'S OFFICE
NURSING HOME AGREED UPON PROCEDURES

PROVIDER	WORK AREA	PERIOD
----------	-----------	--------

Non-Covered Medical Expenses

Description	Done By and Date	W/P Reference
(2) If applicable, determine if a statement from a licensed practitioner certifying the item as medically necessary is on file.		
(3) Determine if a monthly log sheet was prepared.		
(4) Determine if a vendor's bill is on file.		
(5) If applicable, determine if the dollar limit was exceeded.		
(6) Verify footings of logs and bills as appropriate.		
(7) Verify any carry-overs into the subsequent month.		

FINDINGS/CONCLUSION: