

**Eligibility Case Review Guidelines  
And  
Eligibility Case Review Tool**

Division of Public Assistance  
Field Services  
February 2009

## Table of Contents

<b>Introduction</b> .....	3
<b>Purpose and Case Review Types</b> .....	4
Pre-Reviews .....	4
Post Reviews .....	4
<b>A Reviewer’s Roles and Responsibilities</b> .....	5
Regional Case Reviewer and Supervisory Responsibilities.....	5
Regional Case Reviewer Responsibility .....	5
Supervisor Case Review Process.....	6
<b>Review Focus</b> .....	7
Data Collection .....	7
Case Action Types.....	8
Experience Levels .....	8
Quantity of Reviews for Supervisors and Case Reviewer.....	9
<b>Case Selection Methods</b> .....	10
Re-Reviews .....	10
<b>Reviewing Methods</b> .....	11
Post Review.....	12
Pre-Review .....	12
Real-Time Reviews.....	13
<b>Case Review Documentation</b> .....	14
Start New Review .....	14
Case Review Rebuttals (Do Not Concur) .....	16
<b>Correction Time Frames</b> .....	18
Post Reviews.....	18
Pre-Reviews .....	18
<b>Error Types and Elements</b> .....	20
Error Types.....	20
Error Elements.....	21
Primary Error .....	24
Causal Factors.....	24
<b>Pre-Review Process</b> .....	26
Getting Started .....	26
<b>A Step-by-Step Guide to Conducting Post Case Reviews</b> .....	29
<b>Glossary</b> .....	35

## Introduction

An “Eligibility Case Review” is an examination of a specific benefit month program decision resulting in feedback on whether or not policy was accurately applied and benefits were determined correctly and timely. The review reflects the facts of the program and case status as available to the worker at the time of the decision. In addition to addressing case specific issues, case reviews can help staff identify systemic, procedural, and policy concerns that need to be addressed. It is important that this strategy become part of the Regional Leadership’s responsibility to ensure work quality.

The “Eligibility Case Review Process” involves case selection, identification of error types and outcomes, use of the case review tool, and the notification of the review results. The Staff Development and Training unit provides formal training on the process details.

Regional Leadership is measured on how successful they are in meeting the accuracy goals and minimizing error trends for all programs in their region. Success is measured not only by Quality Assurance data, but also by steps taken within the unit/office to make the changes necessary to improve operations and staff performance. Local leadership is responsible for identifying the causal factors, developing action steps for improvement, and documenting and evaluating progress so that the efforts clearly produce results of improved accuracy. Support staff from Program Integrity, Staff Development and Training, Policy and Program Development, Systems Operations, and Field Services is available to assist local leadership.

Regional Leadership is responsible for recognizing environmental factors that cause individual or team performance problems. Action must be taken within their span of control to minimize the environmental factors affecting the quality of work. For example, the redistribution of work, realignment of staff, authorization of overtime, correction of scheduling problems are all examples of local leadership actions to remedy problems that adversely affect quality.

Our goal is to provide better customer service to our employees through frequent feedback regarding their progress both as an individual and collectively as a team. Communicating findings, solutions, and plans should be a regular component of individual conferences and staff meetings.

**Note:** It is important to review these cases immediately to stay within timeframes and to ensure the circumstances of the case have not changed from the original determination.

## Purpose and Case Review Types

The purpose of the Case Review process is to provide staff with feedback on the determinations made for benefits and services administered through the Division of Public Assistance (DPA).

DPA will be administering both a pre and post review of cases.

### Pre-Reviews

Pre-reviews are targeted case reviews completed prior to the benefits being authorized during an application or recertification. The purpose of a pre-review is to ensure critical areas such as household composition, resources, income (including conversion factors), deductions, notices, and case notes have been completed accurately. This type of review should only be administered to ensure workers have a good understanding of policy and procedure. Situations that may benefit from a pre-review include, but are not limited, to the following:

- ❑ All intake and recertification/review approvals and denial/closures when a new policy change is implemented.
- ❑ An experienced worker transfers from one office to another.
- ❑ An experienced worker changes from intake case processing to ongoing case processing and visa versa.
- ❑ A worker's post case reviews reflect a trend in payment errors.

Typically, pre-reviews are considered a "targeted" review because most situations will focus on challenging areas of policy and procedure for an individual. As a result, the likelihood of an error discovery is greater.

### Post Reviews

Post reviews are completed after the benefit has been authorized and issued. This type of review evaluates all of the elements of a case review. It's normally conducted for new eligibility workers or experienced eligibility staff under a performance improvement plan.

Some post reviews may "target" a specific area element, for example household composition. Reviews will be targeted based on the office/individual error rate as well as data and information received from the Program Integrity Unit.

Post reviews can be conducted by the Regional Case Reviewer or Supervisor.

## **A Reviewer's Roles and Responsibilities**

### **Regional Case Reviewer and Supervisory Responsibilities**

The case review process is completed using one of two processes based on regional requirements and availability of case reviewers. The responsibility of the Regional Case Reviewers and Supervisors differ based on the case review process utilized.

### **Regional Case Reviewer Responsibility**

At least one case reviewer is assigned to each region. The responsibilities of the Regional Case Reviewer and Supervisor are as follows:

1. The Regional Case Reviewer completes the case reviews using the online Case Review System. The Reviewer evaluates all of the completed case reviews with the Supervisor of the responsible eligibility worker or unit being reviewed.

Through feedback from the Supervisor and the resulting case review information, the Reviewer gathers all available data for corrective action planning activities.

The Regional Case Reviewer is key in assisting the Regional Manager to develop pertinent and value-added corrective action plan activities for the entire region. The corrective action plans outline goals and specific steps the region will take to improve performance.

2. The Supervisor uses the case review information provided by the Regional Case Reviewer to complete the following:
  - Conference with the eligibility worker to review the case review information.
  - Ensure any necessary corrections are completed and returned within appropriate timeframes.
  - Identify additional support and training needs.

Worker conferences are instrumental in identifying policies and procedures, which should be discussed during staff meetings to improve overall unit performance. Supervisors solicit workers' suggestions for enhancement of case processing and incorporate the information into the overall system for improvement.

## **Supervisor Case Review Process**

Conducting regular and thorough Supervisory Case Reviews is vital to ensuring work quality, assessing performance, and developing skills of staff. The responsibility of the Supervisor is as follows:

1. The Supervisor completes the case reviews using the online Case Review System.

The Supervisor works with the Regional or Site Manager to develop pertinent and value-added corrective action plan activities for their unit. The corrective action plans outline goals and specific steps the unit will take to improve performance.

2. The Supervisor completes the following:
  - ❑ Conferences with the Eligibility Technician to review the case review information.
  - ❑ Ensures that any necessary corrections are completed and returned within appropriate timeframes.
  - ❑ Identifies additional support and training needs.

The ET conferences can also be instrumental in identifying policies and procedures that should be reviewed during staff meetings to improve overall unit performance. Supervisors should ensure questions on how case processing can be improved should be asked and fed to the overall system for improvement.

Supervisors may routinely delegate to a lead worker a limited number of case reviews as a means to develop case reviewing skills and to supplement reviews for the Supervisor and Regional Case Reviewer.

The Regional Case Reviewer/Supervisor utilizes the online Case Review System to complete all case reviews for FS, TA, ME, APA, GA and CAMA. Priority of the case review is based on the results of data collected. With assistance from the Regional Manager, each office determines where the emphasis is placed on case reviews. Other factors to consider are case action types, staff's experience levels and the quantity of reviews within an office. All of these criteria can help offices determine the review focus.

### Data Collection

Some of the sources of information that can be used to prioritize review selection are:

- ✓ District Office Performance Measures report  
<http://dpaweb.hss.state.ak.us/files/pdfs/DPAPerformanceMeasures.pdf>
- ✓ Case Review System reports
- ✓ Program Integrity and Analysis reports website  
<http://dpaweb.hss.state.ak.us/node/354>
- ✓ FS Error reports  
<http://dpaweb.hss.state.ak.us/node/view/233>
- ✓ New policy changes
- ✓ Client complaints

Example 1: This month's report from the Case Review System indicates 46% of the FS errors are in the area of earned income and result from the misapplication of policy on use of conversion factors. In this situation, the regional manager works with the supervisors and case readers to establish a priority to review all FS intake cases and re-certifications until the error trend has diminished to acceptable levels.

Example 2: A recent FS/TA manual change was distributed that covered the calculation of shelter expenses. All application approvals and re-certifications/reviews are reviewed for overall understanding of the new policy.

## Case Action Types

Regional Case Reviewers and Supervisors will review the following actions:

1. New applications
2. Renewal applications
3. Changes
4. Negative actions (closures and denials) **If incorrect, be sure the 940 – Invalid Denial/Closure error code is used.**

Number of reviews:

- New worker 100% for the first 60-90 days. A minimum of 50 reviews for the first program after formal training.
- A minimum of 25 cases when an additional program has been added
- ET II minimum of 25 reviews of combo/high risk cases preferably spread out during the year at two per month.
- ET III new lead/RCR worker minimum of 25 reviews when first out of case review training. Once experienced, 25 case reviews per year. This can be a combination of re-reviews and QA reviews that had previously had a review done.

## Experience Levels

Targeted reviews are completed for an ET when their experience and performance warrants it as specified by the Supervisor.

Example 1: An ET I receives 100% case reviews for the first three months to allow a fair assessment of the workers progress.

Example 2: An ET I or II, in the intake unit, currently has a payment error rate of 15%. The supervisor and case reviewer conduct 100% reviews on approvals and denials within an agreed amount of time, until the worker can meet an acceptable payment error rate. As an added measure the reviewer conducts pre-reviews for a two-week timeframe to ensure the worker can maintain an acceptable payment error rate.

Example 3: An ET II, transferred to the APA unit and recently returned from APA training. The supervisor conducts 100% case reviews on the actions (approvals and negative actions) of all APA applications and reviews for a month after the training.

## **Quantity of Reviews for Supervisors and Case Reviewer**

The supervisor's role is to augment the case reviews completed by the case reviewer, so their number of reviews may be significantly fewer than those of a case reviewer.

Reviews conducted by case reviewers and supervisors may be within a specific team or supporting other teams. The office evaluates the proportion of reviews to be completed and adjusts expectations accordingly to meet the need.

Supervisors in local offices with multiple supervisors are required to read the following monthly:

1. 20 active combination cases
2. 5 negative combination cases

Supervisors in local offices with only one supervisor are required to read the following monthly:

1. 10 active combination cases
2. 5 negative combination cases

Regional Case Reviewers are required to review up to 100 – 150 cases per month.

When the Regional Case Reviewer goals are not met, the Regional Manager reassesses the reviewer's activities to determine what is acceptable, keeping in mind that case reading is a priority for these positions.

Case reviews conducted by a lead worker are acceptable to accompany reviews performed by the Supervisor and Case Reviewers. It allows the lead worker the opportunity to gain experience and provides assistance to the office to complete reviews.

Regional Managers and local leadership are responsible for monitoring daily completion of reviews utilizing the Case Review System, to ensure that the office meets the targeted goals. It is expected that case reviews are being conducted throughout the month, and feedback provided to staff on a regular basis.

## Case Selection Methods

Cases selected and reviewed through the month include all programs and action types (approvals and negatives). Here are some things to remember:

- ❑ Cases returned for correction or follow-up do not count as a second review.
- ❑ Post-application reviews are only counted once on the final action regardless of the times it was handled.

Listed below are the methods the Regional Case Reviewer/Supervisor uses to select cases for review. The Regional Case Reviewer/Supervisor utilizes these methods to select approvals, negatives (denials/closures), or changes reviewed throughout the month.

The following criteria are used to select cases for a targeted review:

- ❑ New worker 100% for the first 60-90 days. A minimum of 50 reviews for the first program after formal training.
- ❑ A minimum of 25 cases when an additional program has been added
- ❑ Eligibility worker on an improvement plan
- ❑ Intake
- ❑ Renewals

**Note:** See the Review Focus section of this document for more details regarding the selection process for targeted reviews.

### Re-Reviews

To ensure consistency and quality case reviews, a re-review practice is used to evaluate a percentage of completed case reviews. The Regional Case Reviewers re-review a portion of the Supervisor's case reviews and provide feedback to the Regional Manager using the Case Review System. The reviewer is designated as the "worker" on the system.

A portion of all case reviews completed by the original case reviewer are re-reviewed by the Field Services Representative. This information is shared with the Regional Manager. Each office works with the Field Services Representative to determine the percentage of re-reviews to be completed on each Regional Case Reviewer and Supervisor.

## Reviewing Methods

There are several types of case reviewing methods. They are as follows:

### Post Review

The post review process is used to determine if proper policy and procedures were used, and correct verification practices followed. The process of reviewing a case requires evaluation of the following:

1. Information on the application or recertification/review
2. Verification in the case file
3. Documentation in the case file and on CANO
4. Procedures used (EIS, program policy and administrative manuals)
5. Information on EIS

The case reviewer conducts reviews using the Case Review System and the training guide. The Regional Case Reviewer/Supervisor/Lead Worker reviews the case for the following:

1. Compliance with policy
2. Clear and concise documentation of all discussions with the participant and collateral contacts
3. Presence of all mandatory verification or evidence that the information was requested
4. Use of all information available in the case file and EIS

The eligibility worker whose case is being reviewed is responsible for a correct eligibility determination for the current action. A current action includes, but is not limited to:

- ❑ Multiple months authorized on a new application or an added program
- ❑ Actions from a recertification or renewal
- ❑ Actions as a result when working a change

If the case reviewed has an action taken on an application, several months may be reviewed to ensure overall and future accuracy. Incorrect actions occurring prior to the current application are reflected only in the *Case Review Comments* section. The Regional Case Reviewer/Supervisor shares the information with the supervisor of the responsible eligibility worker.

In recipient situations, under status reporting and semi-annual reporting requirements, a case reviewed for current actions may require the reviewer to look back as far as the most current application or recertification/review (which ever is most recent) to determine the accuracy of the current benefit month. All errors become attributable to the eligibility worker under review once that worker has processed a recertification/review/change or has added a program application on the case.

**Note:** Corrective actions based on prior incorrect eligibility determinations result in a payment error against the case under review and are displayed as an error in the Case Review System. The Supervisor must take the results into consideration when citing information in a worker's evaluation.

Example: An ET II is assigned to absorb a caseload that has been vacant for the last three months. While the worker is in process of updating the caseload the Regional Case Reviewer conducts a random review of a FS/TA case. In the review, it's discovered a household member that should have been added to the case at the time of the initial application five months ago, was incorrectly coded "OU" by the previous eligibility worker. Since that time, the household called only once to report the income of the PI had started. Benefits were recalculated and the current eligibility worker issued the adjusted benefits. In this situation, the current eligibility worker acted correctly, but because of the actions or inactions of the initial worker the overall benefit amount is incorrect. This constitutes an error to the case and the worker is cited with a payment error. Since the case has a payment error the reviewer must record the findings on the case review system.

## **Pre-Review**

Cases selected after the interview and authorization, but prior to the issuance, are reviewed to determine the thoroughness and accuracy of the determination.

After the ET completes the application, authorizes benefits, documents case notes, and completes the notices, a case review is done to ensure case is complete and accurate. The case reviewer provides immediate feedback about policy and processes that are applied correctly as well as providing information and support on the correct application of policy and procedure.

The pre-review process requires evaluation of the following:

1. Information on the application
2. Verification in the case file
3. Documentation on the Case Notes (CANO)
4. Information in the Eligibility Information System (EIS)

The Case Review System is used to track results from the pre-reviews. The Regional Case Reviewer/Supervisor/Lead Worker reviews the case for the following:

1. Compliance with policy
2. Clear and concise documentation of all discussions with the participant and collateral contacts
3. Presence of all mandatory verification or evidence that the information was requested

#### 4. Use of all information available in the case file and EIS

In circumstances where a food stamp household is approved benefits under expedite criteria and the holding of benefits will cause the food stamp case to exceed the required timeframes, allow the benefits to be issued prior to the review.

For more processing information, see the Pre-Review Process section. Otherwise, all other criteria follows the post review section.

#### **Real-Time Reviews**

A real-time review is similar to a pre-review in that the case is reviewed prior to benefits being issued. The major difference is the reviewer is observing the eligibility worker process the entire case. Once the case is worked, the reviewer makes an accuracy determination. This performance enhancement strategy allows the reviewer to observe the entire eligibility determination process, It's an opportunity to assess how a worker processes a case and to identify areas of improvement in policy, organization, computer literacy, procedure, writing, and customer service.

## Case Review Documentation

Regional Case Reviewers/Supervisors complete the case reviews using the online Case Review System. All documentation regarding the case review and error analysis is completed in the Case Review System. The information entered in the system is keyed in, and dropdown menus or option boxes provide users with a range of selections to use when documenting a case review.

All documentation regarding the case review is completed on the following screens:

### Start New Review

#### □ Case Sheet

The system uses the EIS case number. The *Find Case* screen is the first in the process and it requires the following input:

1. The case number.
2. If the case number is known to the system due to a previous review, a *Case Sheet* appears with a list of prior reviews. The reviewer is able to review the past reviews.
3. If the EIS case number is new to the system, the *Create New Case* screen appears. The reviewer must enter the appropriate information into *Case Last Name* and *First Name* fields.
4. The reviewer has the option of selecting, *Editing Case* to update an existing review or *Create New Review* to begin the review process.

Note: All information must be manually updated in the Case Review System. There is no direct connectivity to the EIS mainframe from this system.

#### □ Review Sheet

The *Create New Review* screen allows the reviewer to pull over the EIS name and case number and allows the following information to be updated:

1. Type of Review
2. Target
3. Worker
4. Section (aka region)
5. Supervisor
6. Appropriate programs –Be sure to check all open programs for the case. Even when the target may be only one program, we review all open programs.

Once all of the information is logged into the system the reviewer has the option of selecting *Cancel* or *Save New Review*.

## □ Program Analysis

The Program Analysis section denotes the marked programs and allows the selection of the following information:

1. The error analysis: allows the reviewer select the *Error Element*, *Primary Reasons*, and *Causal Factors*. Each selection provides a drop down menu to select the most appropriate option.
2. The benefit history for the months and amounts authorized. After the case review is completed, the final amounts are keyed in for both correct cases and cases which require corrections. **Reminder: If reviewing an application or recertification, start with application month and move forward to the current system month.**

## □ Case Summary

The case review summary screen is used to key in comments regarding the case review. When a case error or payment error is cited, the reviewer quotes a policy manual section or EIS procedure that supports finding.

Guidelines for Case Summary section: There are three elements to this section.

1. Short narrative (no more than 2-3 sentences) about the case.
2. Error – where you list the error(s), if any.
3. Comments on the remainder of case, by EIS screen sequence. Separate each section by using the enter key and inserting a blank line and identify the section by screen name i.e. SEPA, EAIN, DEMH.

Note: Keep your comments professional, informative, and to the point. Statements such as “what were you thinking”, “you got lucky this time”, “duh!” are not appropriate, even if you know the worker well. In most instances it is best to refrain from using the word ‘you’. For example, instead of writing “you forgot to check the DOL interface” write “DOL interface shows client began receiving UIB on 3/25/07”

Your comments should be clear and concise sticking to the facts of the review. Overly long comments can be confusing and take too long to review. For many workers, it may be better to discuss findings in person.

## ▪ Review Status

The reviewer will set the *Review Status* of the case. A drop down menu allows the choices of *Started*, *Open*, *Responded* and *Closed*. For non-case errors, this is the section to address required case adjustments and discrepancies.

## □ Print Review

The reviewer has the option of viewing the *Case Review Sheet* or printing the case information.

Following the discovery of an error or potential error, the Case Reviewer discusses the error with the responsible Supervisor and returns the case and case review information. The Case Reviewer returns the case to the Supervisor the same day the case review is completed when possible, but no later than the first workday following the day the case review is completed.

The eligibility workers make comments on any question cited with an error, by clicking on the *Respond* option on the *Cases Assigned to Me* screen.

When the eligibility worker returns the case with the correction, the Reviewer must complete all of the following:

- Ensure all the appropriate corrections have been made
- If the eligibility worker rebuts the finding of results, the Reviewer determines whether the eligibility decision was correct or resulted in an error. For more information, see *Case Rebuttals (Do Not Concur)* section below.

When an error is cited in one program that has an adverse action on another program, this does not count as a payment error for the otherwise correct program. Example: The ATAP benefit was in error. The food stamp benefit was calculated with the incorrect ATAP amount. However the food stamp benefit is not in error because it counted the ATAP amount that was issued according to FS policy.

### **Case Review Rebuttals (Do Not Concur)**

When the results of a case review are rebutted, the following procedures must be followed:

- When the eligibility worker does not agree with an error finding, the worker responds to the review using the Case Worker Response.
- The Supervisor reviews the rebuttal and determines the next step – to concur with the worker, seek clarification, or allow the decision to stand.
- When the Supervisor does not agree with an error cited by the Regional Case Reviewer, they discuss their reasoning with the Case Reviewer.
- When an agreement cannot be reached:
  1. A memo or email outlining the justification is sent to the Field Services Review Representative.
  2. If a policy clarification is needed, an email is sent to the Program and Policy unit.

- The Field Services Review Representative reviews the rebuttal and, if necessary, may confer with the Supervisor, Eligibility Worker and the Case Reviewer. A final decision is rendered at that time following this review.

## Correction Time Frames

The time frames to complete corrections on case reviews citing potential errors are as follows:

### Post Reviews

While error cases should get immediate attention, a worker has ten days to correct the case (holidays and weekends are included). The eligibility worker must initiate corrections to benefits and send appropriate notices. The Case Review System allows the flexibility for requesting corrections within three, five, seven or ten days. If applicable, the case may be corrected on the day the case is returned from the supervisor. The supervisor must advise the worker of the need to expedite the case correction.

Extensions are granted when appropriate, for example, additional information is required. It is the responsibility of the eligibility worker to request the extension from the Supervisor. The Supervisor notifies the Case Reviewer when the case review is conducted by the Regional Case Reviewer.

A case may be returned to an eligibility worker to request additional information that could affect the benefit amount. The reviewer cites the case review as an error until the information is received. When the client does not provide the information and the result is a case closure or denial, the case is cited as incorrect. The total payment amount the eligibility worker would have issued is counted as a payment error.

When a case is returned to the eligibility worker for corrections and the due date extends into the following months, the case is counted as a review in the month it was actually reviewed.

### Pre-Reviews

When case accuracy is reviewed prior to issuance, the eligibility worker updates the case at the time of the case review. If additional information is needed, the eligibility worker pends the application or recertification for additional information. However, if the case meets expedite criteria or, the appropriate benefit months are authorized and the information is requested. For case reviews involving a review, timely notice for adverse action must be considered when requesting information.

Once the case review is returned with the eligibility corrections, the Regional Case Reviewer/Supervisor updates the benefit amount reauthorized in the *Final* amount field on the *Program Analysis* screen. Any difference from the original amount authorized displays as a payment error.

When an error is cited, but the corrected case does not result in a payment error or an incorrect eligibility decision, it is considered a correct case.

In situations where the case review has a correct payment determination, but contains deficiencies that require updates, it is considered a “no error” case. To ensure the case is corrected, the case reviewer leaves the review in “open” status. Once the deficiency is corrected and the eligibility worker responds, the reviewer reverts the case to “closed” status.

## Error Types and Elements

Once a case is reviewed for accuracy, the reviewer will determine the type of error and the error elements. The elements include the Error reason, Primary Reason and Causal Factors. The following are descriptions of each:

### Error Types

There two types of eligibility errors:

#### 1. Payment Error

A payment error is the difference in dollar amount granted or withheld from the household's original payment determination. The following situations cause a payment error:

- a. An authorized and/or issued benefit payment, in any amount, to an ineligible household
- b. An authorized and/or issued payment resulting in \$1 or more overpayment or underpayment in a benefit to an eligible household
- c. An unauthorized or de-authorized benefit to an eligible household  
Note: Supervisory discretion is used when a case under review was de-authorized due to no fault of the eligibility worker.
- d. All incorrect denials and closures

#### 2. Case Error

A case error is based on the eligibility and level of eligibility granted to a household. Note: All payment errors are case errors in the tool. Errors less than \$26 will be excluded from a case workers CAR in evaluations. Any anecdotal information gathered from errors less than \$26 may be addressed in other areas of the evaluation.

Since the Medicaid case review is based solely on eligibility, all errors cited are considered case errors. No payment amount is determined when conducting a Medicaid review and these cases are not subject to a payment error.

In addition to financial and other non-financial eligibility requirements, these areas are countable eligibility errors that can result in a claims payment error, and need to be reviewed for correctness.

- a. Third Party Liability: Was there third party insurance that the client reported started or stopped and the MIBW and MERI were not updated correctly.
- b. Pregnant woman: Was verification received and coded correctly on the MIBW and MERI (code 11 thru her post partum period.)
- c. Citizenship and identification: Were they verified according to policy and HERC screen coded correctly

- d. Cost of Care liability: Was it under/overstated – COCA screen.
- e. SCHIP: Were children coded to a title 21 category (CP, H2, S2) when they were eligible for a title 19 category (HC, SU, H1, S1 etc)
- f. Missing Documentation and Case Notes. Missing documents such as verification of pregnancy indicating the EDD, transfer of resources declaration, trust accounts, etc.

## **Error Elements**

If a review results in an error, the Case Review System provides drop down menu to select the overriding error element for that review, regardless of the month the error occurred. Each error element has a corresponding number to statistically track error trends. The following are the codes and some examples of error situations:

- ❑ No Error (0) – No payment or case error found. This display is the default code.
- ❑ Need More Information (00) – This code is used to notify the eligibility worker to provide the case reviewer with requested information needed to complete the review.
- ❑ Citizenship and Identity (130)
  - Eligible Person(s) excluded
  - Ineligible Person(s) included
- ❑ Residency (140)
- ❑ Household Composition (150)
  - Client provided change of household information, but change was not processed
  - Worker included a household member who should have been omitted
  - Separate household status for “purchase and prepare” relationships of members was not correctly established
  - Age criteria requiring (or not) to be a member of the program household
  - Alien included or excluded in error
  - Information that a household member quit a job without good cause was not processed or the penalty was not correctly applied for voluntary quit
  - Felon disqualified not acted upon
  - Penalties not acted upon or acted in error
- ❑ Social Security Enumeration (170)
  - Eligible Person(s) excluded
  - Ineligible Person(s) included

## Resources

**Note:** Document resources that should have been included or excluded

- ❑ Liquid Resources (211) - bank accounts, cash on hand, U.S. savings bonds, lump-sum payments, stocks and bonds, and monies held by third parties
- ❑ Nonrecurring Lump-Sum Payment (212)
- ❑ Other Liquid Assets (213)
- ❑ Real Property (221)
- ❑ Vehicles (222)
- ❑ Other Non-Liquid Assets (224) - those not specifically listed above
- ❑ Combined Resources (225)
  - Client failed to provide the correct information regarding resources
  - Agency received resource information requiring a specific action but did not act on it
  - Resources exceed prescribed limit
  - Resources of an excluded household member not considered
  - Reported resources used but incorrectly applied
  - Inconsistent resource information not questioned or resolved

## Income

- ❑ Earned Income (311)
  - Unreported earnings of self or other household members
  - Agency received earnings information that requiring a specific action but failed to take action
  - Agency received pay stub information, but used the wrong amount from the pay stub to calculate earned income
  - Method used to determine estimated income was not documented completely enough for the estimate to be verified as “reasonable”
  - Reported earned income used in budget but incorrect policy applied
  - Excluded income incorrectly counted
  - A mathematical error in calculating the total earned income to be used in benefit calculation
  - New employment with hourly gross pay incorrectly converted to monthly
  - Excluded overtime that is expected to continue
  - Failed to use available actuals in application month
  - Conversion factors misapplied
- ❑ Self-Employment (312)
  - Cost of doing business policy incorrectly applied or omitted from calculation
  - Client failed to report earnings (crafts, baskets, etc.)

- No action taken on self-employed income reported by the client
- Child or Dependent Care Deductions (323)
  - Child care deductions incorrectly applied
  - No action taken on child care expenses reported by the client
  - Subsidized child care incorrectly allowed as an expense
- RSDI Benefits (331) – AKA SSA benefits
- Veterans Benefits (332)
- SSI and/or State SSI Supplemental (333)
- Unemployment compensation (335)
- Other Government Benefits (336)
- PFD Hold Harmless (337)
- Contributions/Income In-kind (342)
- Other Unearned Income (346)
  
- TANF (347)
  - Unreported source of income
  - Income was known but not included
  - More or less income received from the source than budgeted
  
- Child Support Payments (350) – received from the absent parent
  - Unreported source of income
  - Income was known but not included
  - More or less income received from the source than budgeted
  - Retained child support not considered or incorrectly applied
  - Pass through payment not considered or incorrectly applied
  - Information provided by NFIN and did not act on it
  
- Shelter Deduction (363)
  - Deduction should have been included or excluded
  - Incorrect amount used resulting from a change in residence
  - Client receives a subsidy that reduced the shelter costs – reported but not considered
  - Taxes and/or insurance conversion to monthly amount not used or incorrectly applied
  
- Utilities (364)
  - Incorrect or no information received regarding utility costs
  - Information triggers a specific action and the worker did not act on it
  - Household reported a move and provides new utility cost verification, previous utilities still appear
  - Utility cost allowed when there is no cost incurred by the household
  - SUD or non-heating deduction applied when no cost was incurred
  
- Child Support Payment Deductions (366)
  - Policy incorrectly applied or omitted

## **Other**

- ❑ Categorical Eligibility (910)
  - Case closed in error
  - Allowed to an ineligible household
- ❑ Notices/Adverse Action (920)
  - Adverse action was not used to decrease benefits
- ❑ Benefits Not Authorized - Alerts (930)
  - Staff failed to act on alert
- ❑ Invalid Denial/Closure (940)
- ❑ TPL/TPR Category (950)
- ❑ COCA (951)
- ❑ Other (990)

## **Primary Error**

The primary error describes the nature of the error element:

- ❑ Client failed to provide information
- ❑ Client provided incorrect information
- ❑ Failed to act on information - Agency
- ❑ Failed to request information - Agency
- ❑ Incorrect calculation keyed - Agency
- ❑ Incorrect procedure - Agency
- ❑ Misapplied policy - Agency

## **Causal Factors**

The causal factor provides the determining reason for the primary error.

- ❑ Averaged incorrectly
  - Averaged income or expense not used or incorrectly applied
- ❑ Change at Application
  - New or updated information provided at application or recertification/review, but information was not acted upon

- Detail Overlooked
  - Transpositions or computation error occurred
  - Alert not acted on
  - Computer user error
  - No follow-up on inconsistent or incomplete information
  
- Documentation
  - Case note does not reflect the method for actions taken on EIS
  - No justification in the case note for allowing or disallowing income or expenses
  - Case notes do not address questionable information , such as a reason the client provides for living beyond the means of the household
  - Information within the case file that triggers a specific action
  
- Failure to Check Policy (misapplication of policy)
  - Use of wrong policy or incorrectly applied
  - Required verification was not used or requested
  
- Incorrect Budget
  - Did not consider income was beginning/ending
  - Averaged inconsistent paychecks
  - Did not consider missing paychecks
  
- None – default
  
- Unresolved Discrepancy
  - A request for additional information was requested as a result of a case review, but household failed to provide or reply.
  - A review that was never responded to by the worker.
  
- Wrong Conversion Factor
  - Example: A recipient begins a new job with paydays on the 5<sup>th</sup> and 25<sup>th</sup> of each month. The eligibility technician uses the conversion factor of 2 for a pay period, instead of using an average weekly work schedule and applying a conversion factor of 4.3 to determine the expected monthly income.

## Pre-Review Process

The pre-review process targets cases of experienced workers to assure accurate benefits prior to issuance to the household. The focus of the review is in the error-prone areas identified by QA and Regional Case Reviewer/Supervisor.

The pre-review allows for flexibility based on staff's need for support. As policy, procedures and local staffing change, so can the focus of the pre-review. Each office, with assistance from the Regional Manager, determines the elements that are particularly challenging and focus the review on those elements.

Because it is targeted, the pre-review process does not consider all of the aspects of policy and procedure and it is not expected to replace a full review. This type of review should only be used with experienced workers who possess policy and processing knowledge. Because these reviews are targeted, it assumes that the worker::

1. is knowledgeable of the programs they are authorized to administer.
2. comprehends all interfaces and the applicable extraction of information.
3. has collected all appropriate documentation outside of the targeted areas, such as the 1603s.

Note: A worker requiring more knowledge (e.g. a new worker) may need a more comprehensive review. It is up to the supervisor to make that determination.

### Getting Started

Before a pre-review is completed, the worker must complete the case processing which includes the notices, case notes, and authorization of benefits for all months. Pended cases do not require a review.

Note: Benefits and notices should not be held up for the pre-review.

#### □ Printing information for the Reviewer

To expedite the review process it is preferable for the eligibility worker to print the budget screens (MIAU, TAPD, FSAD, etc) for all the months authorized, suspended or denied/closed, and the CANO screens. If the authorization/denial was based on a previous pend, print all CANO' that apply to that eligibility determination.

Example: The worker authorized three months of FS benefits (October, November, and December). Print the initial intake CANO that started the pend, any subsequent CANO that addressing information affecting eligibility and the authorization case note.

❑ **Conducting the review**

The pre-review is a one-on-one process with the worker, at the worker's office space.

The reviewer checks the application or recent recertification/review, attached documentation (such as interface checks), and case file (if available).

**First initial application month or current month for a Recertification or Review:**

Check the following -

- CAP2 – Look at the ARD and BSD to see if it aligns correctly with CANO and action. Look at the status to ensure that benefits are in current month.
- The review determines the use of correct coding for the targeted information. Here are some examples:
  - ❑ Household Composition
    - SEPA – compare to the application and CANO. Check to see if there are any disqualifications and that the SEPA is coded correctly.
  - ❑ Resources
    - FIAC/LIAS – compare to application and CANO.
    - OTAS/VEHI – compare to the application, CANO and INGENS (property & vehicles)
    - TARE/FSRD
  - ❑ Income
    - UNIE/UNIN – compare to the application, CANO, hard copy documentation and DOL printouts. Determine if actuals or conversion factors are correctly applied.
    - EAIN – compare to the application, CANO and hard copy documentation.
    - SEEI – compare to the application, CANO and hard copy documentation.
  - ❑ Deductions
    - DEMH – compare to application, CANO and hard copy documentation in the file.

**For Applications: Review the second and subsequent months:**

Check the following, if applicable -

- SEPA - Look for changes to the household from previous month
- TARE/FSRD – make sure the information has been carried forward
- UNIE/UNIN/EAIN/SEEI – make sure any ending income has been appropriately removed and correct conversion factors are applied

- DEMH – appropriate deductions are carried forward to the second month

**Other areas:**

- NOHS – look for the appropriate notices
- FSBH/TABH/MEBH – to make sure the benefits have not been deauthorized.

Provide feedback to eligibility worker and complete the results on the Case Review System noting the outcome of the review.

**Hint: Scheduling time with the worker**

It is preferable to schedule a review time with the eligibility worker. This allows staff to fit the review into their schedules. Figure about 15 minutes per application to review the first two beginning months. If there are three months or more, it takes longer.

## **A Step-by-Step Guide to conducting Post Case Reviews**

Do I have to use this process?

Many experienced reviewers have cultivated their own review process. While there is no mandatory or standardized approach to conduct a case review, the following can be used as an aid to those less familiar with case reviewing. The features of the entire workbook are simultaneously used to compliment the Case Review Guidelines. The steps listed below reflect the “best practices” of some of the division’s top case reviewers. Use these methods to help you through the case review process.

**Step 1: Begin with the CAP1, CAP2, CASS**

All provide an overview of the programs, the household composition and special considerations

- Post the basic statistical information on the Case Review system.
- Scan the entire screen and compare the information to the most current information or application.
- Print the CASS for the household composition portion.
- Review the CASS screen for each month reviewed as applications will have multiple months.
- Watch for:
  - “DI or DJ” household members.
  - Changes from month-to-month on household composition; income starting or stopping; deductions starting or stopping.

**Step 2: Check the Issuance and Authorization screens**

The authorization and issuance screens allow you to post benefits amounts on the Eligibility Case Review System, and gives some other information to consider.

- Current benefits authorized and/or issued.
- Household composition changes from previous months.
- Income changes from previous months.
- Deductions applied.
- Type of benefit – regular, expedite, supplement, etc.
- TAIH: pass-through issuance dates and supplemental issuances.

**Step 3: Check the CANO**

Read through the CANO. The information within must explain the action taken and the circumstances around the action. It is helpful to read the previous CANO to ensure all facets of eligibility were considered in the current action.

- The determination was properly documented
- The worker followed the CANO guidelines
- All relevant information was entered on the CANO
  - Example: circumstances supporting decision to apply a penalty
- The CANO completed on the day of the action

- Hint: if reviewing a denied FS application for “failure to provide information,” review case file to determine if client provided information within the 60-day timeframe.
- Scan through the previous CANO titles to determine if past documentation affects current benefits.

Step 4: Review the Application, Review/Recert or Report of Change form in detail

- Compare current information with the documents in the case file.
- Go back several months if necessary.
- Look for any changes (i.e. telephone numbers, rent amounts, etc.).
  - Any change such as telephone numbers or rental amounts may be an indication that the client moved and this may effect household composition.
- If any changes are found, investigate “why” the change occurred.
  - It may require more investigation in the case file and possibly contacting the client.

Step 5: Check ETAL for...

- Wage hits
- CSSD actions
- Unemployment benefits
- Report of changes

Step 6: Check interfaces and EIS screens for income, resources, and other eligibility factors

- CSSD: child support income, deductions and cooperation.
- DOL: unemployment benefits and possible unreported wages (BTWI, BB53, BB52, BB05).
- INME #10: on all household members for possible SSA, SSI, etc.
- SVES: possible drug felons, and quarters of work.
- INGENS: resources (vehicles, property, etc.), possible drug felons, business licenses
- SOLQ: SSI, SSA, Medicare

Step 7: Check the case file

- Check the ROPD for the following:
  - Proof of specified relative
  - Qualified alien documentation and if all possible avenues were checked to ensure eligibility
  - Citizenship and Identity documents
- Check sections One and Two for the following:
  - Lease agreements
  - Past and current Report of Change forms
  - Community Physical Exam

- Completed and current 1603's
- Diversion Agreement
- All information for adding a baby is on file
- Copy of completed IAR form on file and original forwarded to SSA.
- APA 4, MED 2, and other documents sent to DDS
- Drop-filed items not acted upon
- PFD forms reporting possible countable resources or paid shelter costs.

Step 8: Check the demographic and resource screens

- Check the SEPA for:
  - Correct participation coding, especially aliens and stepparents
  - Check to see that all MFU members are coded in the household pay close attention to DI, DJ and DF clients
- Check APID, SPRD and CSEA for:
  - Correct entry of the absent parent
  - Correct deprivation reasons
- Check WOSA for:
  - Penalty in effect or expired
- Check the FIAC, LIAS, OTAS and VEHI for:
  - All resources listed on the application, review or recertification
  - Any resource changes reported. Determine whether the LIAS and FIAC were updated if the case was closed due to exceeding the resource limit.
  - All resources discovered through the INGENS search
  - Correct coding (example: use of LV or ER)

Step 9: Check the income screens

- The UNIE & UNIN screens:
  - Check educational income and ensure correct calculations where made and documented
  - On the UNIN watch all TA benefits with an EX sub-type, all countable pass-through payments should be coded with correct PT code
  - Check for prorated TA payments for DI aliens for FS purposes
  - Look for the correct conversion amounts
  - Correct information carried over from the previous month

The EAIN screen:

- Review pay stubs in the case file
- Check pay stubs for advances, tips, reimbursements, etc. Was that taken into consideration when the income was calculated? Example: Laundry & meals.
- Hint: sometimes tips are listed in the pay stubs, but may not be a true reflection of actual tips received
- Check pay stubs for raises

- Check the pay stub for possible resources (examples: stock purchases, IRA deposits, etc.)
- Check to see if all dependent allowances are included in the prospective income for military personnel
- Look for seasonal income or seasonal self-employment
- The SEEI screen:
  - Verify allowable expenses
  - Check to see if all income should be annualized or seasonalized
  - For seasonal income, look for the number of months correctly factored

Step 10: Check the deduction screens

- The NOMD screen:
  - Are all deduction codes by the correct household member
- The DEMH screen:
  - Verify proof of deductions
  - Compare rent or mortgage payment to hard copy lease or mortgage statements
  - Check the SUD allowances, is the client eligible for SUD based on verification?
  - If there is no verification on file, determine if the client received notice to provide proof
  - Watch for SUD allowances for ASHA or Section 8 housing – rare for client to pay for heat
- Hint: If appropriate, was an ETAL set for insurance or tax changes yearly to make adjustments? Not an error, but will assist with future changes.

Step 11: Check the MIBW for...

- Correct budgeting codes
- Correct Medicaid subtype
- Correct certification date
- Baby coverage w/start date in birth month
- Ensure the correct PF5 (applicant) or PF6 (recipient) key was used
- Check other cases to see if HH members are still participating on other, i.e. 2 children on DKC and 2 children on FM
- Check for correct Med Ins indicator if there was TPL

Step 12: Check the MERE & MERI screens

- MERE:
  - Correct Sub-Type
  - Correct Eligibility Code
  - Correct HIC number (if applicable)
- MERI:
  - TPR listed by all appropriate household members
  - TPR policy number is the SSN of the policy holder

- MCR code correct
  - QMB code J
  - SLMB with auto part A, code J
- TPL

Step 13: Check the payment screens

- TAPD
  - Check the income and month to see if it corresponds with the information listed on the CANO and other documentation
  - Correct household type
  - Correct issuance code
  - Check the shelter allowance. If there is a deduction, consider whether actual deductions would have applied in this situation to reduce or eliminate the Shelter Allowance
  - Appropriate review date
  
- FSAD
  - Check the income and month to see if it corresponds with the information listed on CANO and other documentation
  - Categorically eligible household determined correctly
  - Correct issuance code
  - Appropriate recertification date
  
- APAS and APMM:
  - Correct household type
  - Income matches the information on the CANO and other documentation
  - All allowable deductions were entered
  - Appropriate review date
  - Ineligible spouses income correctly applied
  - Couple Cases: both benefits authorized
- Hint: Recheck the Issuance screen to ensure benefits are not de-authorized

Step 14: Check the NOHS

- Was the client sent all appropriate notices?
- Were the notices clear?
- Was timely notice for adverse action taken within the appropriate timeframe?

Step 15: Determine Case Accuracy

Complete the Eligibility Case Review tool.

Note: If the worker is required to correct/update the case...

- Review the case file and EIS screens once again to ensure that it is correct. If it affects the current month's benefits, review that month to ensure future months are correctly issued.
  
- Optional: Review the claim determination  
Client-caused errors do not allow the deductions for the portion of unreported (or late reported) income.

<b>Approval</b>	The case action resulting in authorization of benefits.
<b>Case Error</b>	A case review resulting in an ineligible case, an unauthorized or deauthorized benefit, an over payment or under payment of more than \$25, or an incorrect denial or closure.
<b>Case Reader</b>	A designated person to determine the accuracy of which a household is entitled to public assistance program(s).
<b>Case Review Login</b>	The individual's DPA network login to access the Case Review System.
<b>Case Review Queue</b>	A page on the Case Review System where the review data is stored.
<b>Case Review System</b>	The web-based case reading system to conduct the case review process. Effective 5/1/04, this system replaced the Case Review Tool.
<b>Causal Factor</b>	A determining element for the error.
<b>Closure</b>	A Public Assistance recipient fails a factor of eligibility and action to close the case was authorized.
<b>Correct Case</b>	The final action taken by the eligibility worker does not cause a payment error or a case error.
<b>Current Action</b>	All aspects of eligibility, including multiple months authorized on a new application or an added program; actions from a recertification or renewal; and actions as a result when working a change.
<b>Eligibility Worker</b>	An eligibility technician or a workforce development specialist who's responsibility to determine eligibility and benefit amount for Public Assistance programs.
<b>Error</b>	A broad category of overall error element for a specific program.
<b>Incorrect Denial/Closure</b>	A denial or closure action conducted in error.
<b>Ineligible</b>	A non-qualified household erroneously authorized benefits.

<b>Non-payment Error</b>	An unauthorized or deauthorized benefit to an eligible household.
<b>Over Payment</b>	Authorized and or issued payment resulting in more than a \$25.00 issued in error to an eligible household.
<b>Payment Error</b>	The dollar amount of the error granted for ineligible cases; those cases over or under paid; those benefits not paid; and incorrect denial closures.
<b>Pended Case</b>	Final determination being held awaiting additional information.
<b>Post-reviews</b>	Reviews completed after benefits and notices are issued.
<b>Pre-reviews</b>	Targeted case reviews completed prior to benefits and notices being issued.
<b>Primary Reason</b>	Reflects the nature of the error element.
<b>Quality Assurance</b>	The Quality Assurance team is responsible for measuring the state's accountability outcomes.
<b>Recent Reviews (closed)</b>	Case review status showing completed reviews with a final determination.
<b>Regional Reviewer</b>	The case reviewer designated to conduct case reviews for a specific region.
<b>Reviews Open</b>	Case review status where the reviewer has conducted the case review and the eligibility worker must respond.
<b>Reviews Responded</b>	Case review status where eligibility worker reviewed the findings and has replied to the case reviewer.
<b>Reviews Started</b>	The case reviewer has initiated the review process.
<b>Supervisory Case Review</b>	A type of case review that randomly select cases completed by the Supervisor.
<b>Targeted Review</b>	A type of case review selection, which has been identified as an area of improvement.
<b>Under Payment</b>	Authorized and or issued payment resulting in more than a \$25.00 under-issued in error to an eligible household.