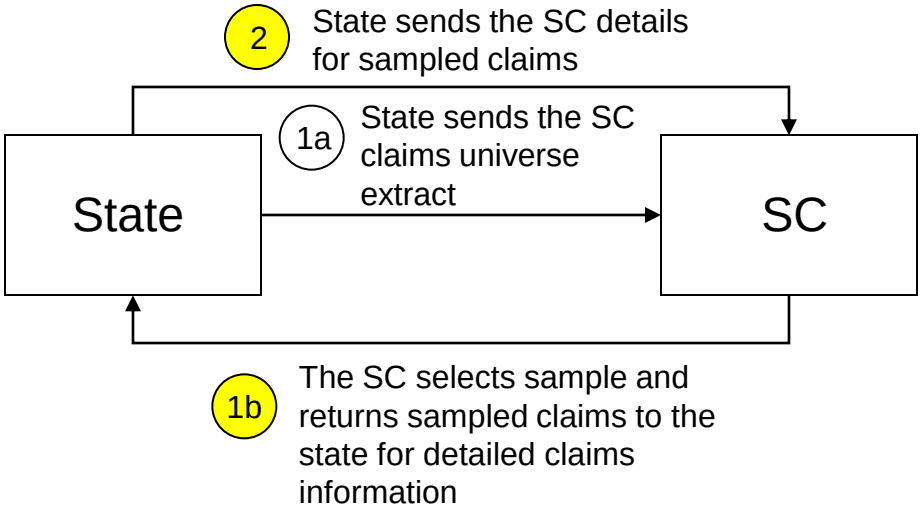
Payment Error Rate Measurement (PERM)

Fee-for-Service Details Intake Meeting

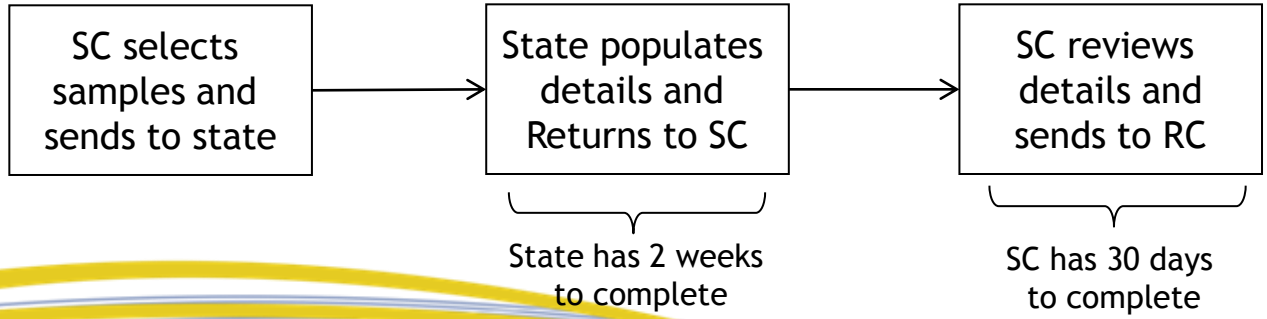
Cycle 1
FY2012

Obtaining details for sampled claims is the second critical step in the PERM process



The SC and state work closely together during the details collection process

- The SC will draw samples from each FFS universe based on the pre-determined state specific sample sizes
  - State will need to collect detail data for both Medicaid FFS and CHIP FFS samples
- After samples are selected, the SC will send them to the state and request the details
- State populates the details and returns the samples to the SC
- The SC converts the state files into a standardized format
- The SC sends formatted detail files to Review Contractor (RC)



Detail fields to populate

- Universe submissions only require minimal variables for each payment
- Details submission require approximately 80 fields
- Key pieces of information include:
  - Beneficiary and provider information
    - Including up-to-date provider contact information
  - Medical service information
    - Service codes
    - Diagnosis codes
    - Dates of service
    - Units of service

Additional claim lines are needed to facilitate medical review

- Details for a sampled claim need to include all lines associated with that payment
  - If a sampled inpatient hospital claim is paid at the header and has 20 detail lines, the header and all 20 lines must be included in the details
  - If line 5 of a 10-line physician claim is sampled, all 10 lines and the header record will need to be included in the details

Claims sampled at the header should include claim header information on every line

The amount paid at the header of the record should appear as the amount paid for all associated lines

perm_id	clm_id_icn	clm_type	date_of_payment	source_location	payment_status	amt_paid	line_number
AKM1101F001	1234567	INPATIENT	10052010	MMIS	P	18559.42	1
AKM1101F001	1234567	INPATIENT	10052010	MMIS	P	18559.42	2
AKM1101F001	1234567	INPATIENT	10052010	MMIS	P	18559.42	3
AKM1101F001	1234567	INPATIENT	10052010	MMIS	P	18559.42	4
AKM1101F001	1234567	INPATIENT	10052010	MMIS	P	18559.42	5
AKM1101F001	1234567	INPATIENT	10052010	MMIS	P	18559.42	6
AKM1101F001	1234567	INPATIENT	10052010	MMIS	P	18559.42	7
AKM1101F001	1234567	INPATIENT	10052010	MMIS	P	18559.42	8

Even though only the header line is included in the universe, the State should submit every line associated with the record in the details submission

Claims sampled at the header should include claim header information on every line

The dates of service should reflect the entire span of time that the claim paid for

Information included on the claim header should be reflected for each associated line

perm id	dos from clm	dos to clm	diag code 1	diag code 2	rev code	place of svc
AKM1101F001	08012010	08312010	43889	431	0191	2
AKM1101F001	08012010	08312010	43889	431	0250	2
AKM1101F001	08012010	08312010	43889	431	0258	2
AKM1101F001	08012010	08312010	43889	431	0300	2
AKM1101F001	08012010	08312010	43889	431	0301	2
AKM1101F001	08012010	08312010	43889	431	0430	2
AKM1101F001	08012010	08312010	43889	431	0434	2
AKM1101F001	08012010	08312010	43889	431	0460	2

The State should include a line for each revenue code the claim paid on

Claims sampled at the line-level should include the unique line information for each line

The amount paid for each service line should be reflected for line-level records

perm_id	clm_id_icn	clm_type	source_location	payment_status	amt_paid_line	line_number	date_of_payment_line
AKM1101F051	123469	PHYS	MMIS	P	95.32	1	11232010
AKM1101F051	123469	PHYS	MMIS	P	19.00	2	11232010
AKM1101F051	123469	PHYS	MMIS	P	45.50	3	11232010

Even though only one line is sampled, the State should submit every line associated with the record

Claims sampled at the line-level should include the information unique to each line

Each line should reflect the date that the individual service was rendered

perm_id	clm_id_icn	dos_from_line	dos_to_line	diag_code_1	proc_code_line	units_of_svc_paid	place_of_svc
AKM1101F051	0321415544001	10242010	10242010	29680	90862	1	17
AKM1101F051	0321415544002	11042010	11042010	29680	99203	1	17
AKM1101F051	0321415544003	11052010	11052010	29680	83909	1	17

Each line should reflect the individual service that the line paid for

The claims detail file requires an intensive quality review process

- Quality control for the claim details involves the review of only a couple hundred claims each quarter, but the data submission requirements are more rigorous than for the PERM universes
- As with the PERM universes, performing internal quality control will save time and resources for your state and CMS

Staff preparation is the basis of effective quality control

- Make sure your state's policy and technical staff are knowledgeable about all of the data fields in the claims detail data request
- Alert Lewin if there are data fields that are not reported in your state system or your team is not clear about the information being requested
- If there are additional state data fields that Lewin has not requested that provide information on payment policy or adjudication, please include the fields in the details file in one of the ten available user fields
- Staff should review all fields and provide Lewin with a crosswalk of all fields provided in the details submission to the names of the fields in the details request

Lewin will review details submission for missing or incorrect data

- During its quality control review, Lewin will check the validity of every value reported in the details file
- Missing Data
  - Your state may not have every field listed in the details request
  - Provide documentation when you submit your details file to explain why a field is missing
  - Check fields that have data for some records and missing values for other records to ensure the missing values are valid for those claim records
  - Full recipient and provider information should be provided for each record

All lines in the details file should carry complete recipient information

- Each field for requested recipient information must be provided for the Review Contractor to request the appropriate medical records for review
- All lines for both header- and line-level sampled records should include this information

perm id	recipient id	recipient name	recipient dob	recipient gender	recipient county
AKM1101F051	7291874	JANE DOE	11191994	F	DENALI
AKM1101F051	7291874	JANE DOE	11191994	F	DENALI
AKM1101F051	7291874	JANE DOE	11191994	F	DENALI

All lines in the details file should carry complete provider information

- The Review Contractor requires contact information for both the Billing and Performing provider for each sampled claim

perm id	prov id	prov name	prov type	prov spec
AKM1101F051	MD02511	MICHAEL SCOTT MD	20	026
AKM1101F051	MD02511	MICHAEL SCOTT MD	20	026
AKM1101F051	MD02511	MICHAEL SCOTT MD	20	026

prov addr 1	prov city	prov state	prov zip code	prov phone	prov npi
2530 DEBARR RD	ANCHORAGE	AK	995082948	9075631777	1194705475
2530 DEBARR RD	ANCHORAGE	AK	995082948	9075631777	1194705475
2530 DEBARR RD	ANCHORAGE	AK	995082948	9075631777	1194705475

State checks to verify that the details submission is complete

- Conduct a frequency check to identify that all core fields are populated
  - Recipient information
  - Provider information
  - Claim type and provider type
  - Dates of service
  - ICD 9/ICD 10 or other procedure codes
  - Line numbers
  - Units of service paid
- Review each record to ensure all of the necessary lines are included in the submission
- Compare the submission to the list of PERM ID's in the sample file to ensure all sampled records are included

State checks to verify that the details submission contains accurate information

- Perform a frequency check to identify any invalid or incomplete values
  - Zip codes (5 or 9 digits only), phone and fax numbers (10 digits only) contain the correct amount of digits and no special characters
  - Procedure codes, DRG codes, NDC codes, and other standardized codes contain the correct number of digits or characters
  - State-specific fields such as ICN/TCN, billing provider number, and recipient number have the correct number of characters
- Compare fields in the sample file to details submission to verify they match
  - Paid date
  - Paid amount
  - Claim type and provider type

State checks to verify that the details submission is formatted correctly

- Conduct a frequency check to identify if any values are out of place
  - Dates in the diagnosis fields
  - Billing provider phone numbers in the address field
  - NDC codes in the procedure code field
- Visually review of all claims to check that each field is properly formatted according to your state layout
  - One suggestion is to review the claims in Excel
  - Filter the claims by state claim type or provider type to limit the number of claims reviewed at one time

Summary

- States must provide details for all sampled Medicaid FFS and CHIP FFS records
- Speed and accuracy are important – facilitates record request, can have significant impact on timeline
- Quality control for the claim details involves the review of no more than a few hundred claims each quarter, but the data submission requirements are more rigorous than for the PERM universes
- As with the PERM universes, doing internal quality control will save time and resources for your state and CMS