



Payment Error Rate Measurement Program
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FY 2010

Payment Error Rate Measurement Program

Medicaid

Fee-For-Service and Managed Care Claims

Detail

Data Submission Instructions

Release Date: May 24, 2010

FY 2010 PERM Detail Data Submission Instructions

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Section One

INTRODUCTION

Section 1: Introduction

Purpose

The purpose of the Payment Error Rate Measurement (PERM) program is to estimate state-level payment error rates and, from these, national-level payment error rates for Medicaid. The error rates will be based on reviews of Medicaid Fee-For-Service (FFS) and Managed Care payments made in the fiscal year under review, as well as eligibility reviews for the same fiscal year. States will conduct eligibility reviews and report eligibility-related payment error rates. See the Glossary for definitions of the terms used throughout this guide as applied to the PERM program.

The Centers for Medicare & Medicaid Services (CMS) announced in the October 5, 2006 interim final regulation that, in response to public comment, it will adopt a national contracting strategy to measure improper payments in the Medicaid program to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). The national contracting strategy for the FY2010 measurement cycle involves two contractors: a Statistical Contractor (SC) and a Review Contractor (RC). CMS has selected Livanta LLC as the SC and A+ Government Solutions (A+) as the RC for FFY 2010 PERM.

As the SC for the FY2010 cycle, Livanta's primary responsibilities are to:

- Receive and review the universe of line items/capitation payments from each state
- Review state eligibility sampling plans and collect eligibility-related error rates from the states
- Sample FFS line items and Managed Care capitation payments on a quarterly basis, which is done through the following steps:
 1. Determine the sample size of line items/capitation payments that will be reviewed for each state
 2. Select a random sample of line items/payments from the universe extract files provided by the state each quarter
 3. Forward the sample selected to the RC and to the appropriate State
- Request additional details for the sampled records from the states and compile the claim details into a standardized format for handing off to the RC
- Collect medical review and payment processing error findings from the Review Contractor for claims/capitation payments
- Calculate each state's Medicaid program error rates using findings from the medical reviews, processing reviews, and eligibility reviews and calculate national error rates for Medicaid for FY2010 based on the states' error rates

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As the RC, A+'s primary responsibilities are to:

- Request state Medicaid medical policies from the states
- Request medical records for sampled FFS paid claims from the providers
- Use the medical policies and medical records obtained to perform the medical reviews
- Perform data processing reviews, either on-site at the state's claim processing facility or through remote access
- Provide its medical and data processing review findings to the SC
- Participate with the SC in writing the final error report

Data Needs of CMS Contractors

The states and the PERM contractors will work to prepare universe files with Medicaid claims, sample from the universe files, and then gather details on the sampled claims. Below is a brief overview of how each contractor uses the data.

- The SC draws a random sample from the quarterly universe files submitted by the states.
- The SC requests the additional claim and line details for the FFS samples and, upon receipt of the detail information, compiles the data into a standardized format for the RC. The data elements included in these claim details will include recipient and provider information associated with the sampled claims, as discussed below and in Section 3.
- The RC is responsible for collecting the information needed to accomplish the processing and medical reviews of the sampled claims.
 1. The RC requests the records supporting the sampled FFS paid claims.
 - Exceptions: Records will not be requested for denied claims, managed care claims, Medicare crossover claims, or FFS fixed premium payments unrelated to a medical record.
 - To request these records, the RC requires states to provide sufficient information within the sampled claims detail data to permit the RC to identify the recipient and date of service and to contact the servicing and/or billing providers to request the record. The more detail that is provided by the state regarding the billing provider, servicing provider, diagnoses, procedures, and recipient, the easier it is for the provider to identify the proper records and return them to the RC within the 60 day timeframe. Records that cannot be obtained from the provider are counted as payment errors due to "no documentation" for PERM purposes. These instructions discuss the required data elements for the sampled claim and line items in more detail in Section 3.
 2. The RC also requests from the states copies of Medicaid program policies (e.g., payment policies, benefit coverage policies) to assist in its medical reviews.
- The RC is responsible for medical review and claims processing review for FFS payments and a processing review for Managed Care. The RC receives from the SC the

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standardized claim and line item detail associated with the sampled claims. For the medical review, the RC refers to the claims data in combination with the record and the coverage and benefit policies provided by each state.

To accomplish the FFS processing review, the RC needs not only the history and detail for each of the sampled claims, but also information from the recipient file (or subsystem) and provider files (or subsystems) and copies of the states' payment policies and fee schedules. The recipient files will include third party liability (TPL) information, spend down indicators, eligibility history, aid category (which will help determine copayment expectations and benefit coverage), and enrollment in other Medicaid programs (e.g., home and community-based waiver). This recipient information impacts claim payment policies, benefit limitations, etc. Provider file data will establish rules regarding application of fee schedules, authorization for provision of certain services, etc.

For the Managed Care processing review, the RC will need a unique record ID, the Managed Care plan identifier, amount and date paid, type of payment (e.g., monthly capitation, delivery kick payment), capitation payment coverage period, and sufficient information on the recipient to establish the accuracy of the payment rate, such as recipient ID, date of birth, gender, county/service area indicator of managed care region and aid category.

The information needed by the RC to accomplish the processing and medical reviews will largely come from the SC, although the processing review will be finalized either on site at the state's claims processing unit or fiscal agent, or through remote access to the state's payment system.

Section Two

OVERVIEW OF THE SAMPLING PROCESS

Section 2: Overview of the Sampling Process

Each state submits a universe extract to the SC of all recipient-specific payments for each of the following two program areas:

- Medicaid FFS (further broken down into record request FFS and fixed premium payments)
- Medicaid Managed Care

The extracts must include the required data elements and conform to the specifications in the Universe Data Submission Information Package provided by the SC. From each of these program areas, the SC selects a random sample of claims, line items, or payments from the universe data, as applicable to each state.

The SC then requests details for the FFS sampled claims from the state. An example of the Data Request Instruction Sheet that will be included in a state detail claim request package is seen in Appendix A. The state provides detailed claim and line information for each sampled unit. Standardized claim detail layouts are included in this package as a separate Excel spreadsheet attachment.

The state returns the sampled unit details to the SC, who standardizes the format and returns it to the state after forwarding to the RC.

For the Managed Care and fixed premium payment sampled records, the state may need to return to the SC any required details that were not included with their universe submission. The SC would have notified the state during the universe process if the state needs to submit missing details for Managed Care or fixed premium payment sampled records

The SC reviews the sampled claim details, converts the data into a standard format, and forwards the claims to the RC. The RC reviews the sampled claims and payments for errors and determines the dollar amounts of the errors. The SC will use the RC's findings to calculate an error rate for each program area.

Section Three
CLAIM AND LINE
DETAILS DATA
REQUIREMENTS FOR
THE SC

Section 3: Claim and Line Details Data Requirements for the SC

Sample Detailed Claims Data: Medicaid FFS

In its Medicaid FFS universe, the state submits an extract of the claims information for all adjudicated sampling units (paid claims and denials) for each quarter. From the universe claims extract, the SC selects a random sample and requests details on the sampled FFS units from the states.

Information to Include in the Sampled Claims Details Data

States are requested to return to the SC detailed information on each sampled item **within two weeks from receipt of the sample**. The detailed information includes:

- Complete claim information: This includes both header-level information and information on all details or lines associated with the claim of the sampled unit. For example, if line 2 of a claim is sampled, the information returned by the state needs to include information from the header and data on all lines associated with that claim header (not just the sampled line). Likewise, if the sampled unit is sampled at the claim header level, all lines and/or revenue codes associated with that claim header must be returned by the state.

Claim details will include all fields necessary for the RC to request a record and for them to conduct a processing and record review. The SC has developed a file layout for sampled claims from the FFS universe. This file layout is contained in the Excel spreadsheet titled *5-2010 PERM Standard Claims Data Formats_052110-Final* and include a list of required fields for most services paid in the state's claims processing system (e.g., health services); these claims are those for which the RC requests documentation from the provider. The file layout for these FFS claim details is contained in worksheet 1 of the spreadsheet *5-2010 PERM Standard Claims Data Formats_052110-Final*, titled FFS Claim Dtls 2010. If the state programs the details using the FY 2009 layouts, there is no need to modify them before submitting to the SC.

- Provider information: The RC would like to have the billing and the performing provider identified on all record request FFS claims (i.e. FFS claims relating to a medical record) in the sample, along with these providers' addresses and telephone numbers. The more up-to-date the state's provider contact information is, the better the chances are the documentation supporting the claims can be obtained. Claims with no documentation submitted are considered payment errors for the full amount of the sampled unit with no opportunity for difference resolution.

It is important that the state take time to review its provider information when submitting details to validate that the provider associated with each claim is who should be contacted for obtaining the record that supports the claim. Be mindful of instances where the billing provider in Medicaid Management Information System (MMIS) is a state agency or other organization; the state may need to dig a level or two down to find out who

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actually rendered the service and maintains the record. The state would then need to include the rendering provider information in the details associated with that claim.

The RC also requests that the state indicate, when sending its claim details, which provider (billing or performing) is most likely to have the documentation that supports the claim. This may vary by claim type for each state.

For all states, complete claim and line details for each sampled unit are requested to be returned to the SC within two weeks of receipt of the sample by the state. The Claim Detail Data Transmission Instructions subsection provides details for transmitting the sample data to the SC, including suggestions for quality control steps the state needs to take to ensure that these data requirements are followed.

Sample Detailed Claims Data: Medicaid Managed Care

Details

When submitting the managed care universe, states were asked to submit complete payment information for all adjudicated sampling units for the Managed Care universes for each quarter, with all fields necessary for the RC to conduct a processing review. The SC selects a random sample, and then asks the states to return any missing details to sampled managed care records **within two weeks of receiving the sample from the SC**. States will only need to submit details for sampled managed care records if their submitted universe did not contain all requested fields. This would have been discussed with the state during the universe submission process

For all sampled Managed Care payments, the state will return only missing details using the file layout contained in worksheet 2 of the spreadsheet *5-2010 PERM Standard Claims Data Formats_052110-Final*, titled FP-MC 2010. It is also acceptable to use the FY 2009 layouts for claim details extraction.

Adjustments

The PERM August, 2007 final regulation requires that the PERM review contractor consider all adjustments made within 60 days of the original paid date. The CMS contractors will consider the net amount paid (original paid amount with additions/subtractions due to adjustments that occurred within 60 days) in calculating the error rate.

Starting with the FY 2010 cycle, The RC will collect appropriate adjustments during the data processing review for both FFS and MC. Therefore, **states do NOT need to submit adjustments to the SC.**

Note that while most states have policies that allow adjustments to be made more than 60 days after the original paid date, only the adjustments made within 60 days are considered for PERM purposes.

Claim Detail Data Transmission Instructions

Data Submission Media

The SC will accept details for sampled claims on CDs and DVDs, appropriately labeled. (See Section 4, Data Security.) The state may also FTP claim details to the SC's secure FTP site; the SC has separate FTP instructions which will be provided to each state upon request.

Data Submission Formats

The state may submit the claims and lines in the standardized format provided by the SC, or in a consistent state format that meets the requirements. (See the related layout spreadsheet included in this communication: *5-2010 PERM Standard Claims Data Formats_052110-Final.*)

The SC strongly prefers that data be submitted in SAS datasets, tab-delimited text files, or an Excel spreadsheet.

Quality Control

Sample Quality Control – Record Request FFS

- Information is included for every sampled unit.
- All required fields are included.
- Claim headers and all details (including the sampled line item and all other line items associated with the same claim or all line items associated with the sampled claim) are included for each sampled unit.
- Records are in the specified layout/format in a separate file.
- Provider information is complete.

Transmission Information

Prior to the initial claims submission, the SC will collect state data dictionaries and decode values for requested data elements. For example, if the state uses local provider type codes, the SC will request the state provide the provider type definitions associated with the codes. Additionally, if the state's ICN or TCN has embedded logic (e.g., the first two digits reflect claim submission media), the SC will request the state submit the ICN logic.

When the state submits their claim and line details to the SC, they must list each file contained on the CD/DVD and a total record count for each file. The file must identify the program (Medicaid) and FFS or Managed Care. It is advised that this information be sent in an email to the SC and the printed email can then be included in the envelope with the CD/DVD. This method has the benefit of alerting the SC as to when to expect data from the state.

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DDC Mailing Address

Address Information for Claims Details Submission:

Mailing Address: PERM SC
Livanta LLC
9175 Guilford Road
Suite 101
Columbia, MD 21046

Email Address: FY10PERMSC@livanta.com

Section Four

DATA SECURITY

Section 4: Data Security

Data will be obtained from states via secure electronic media. The SC's data systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, cartridge tapes, portable hard drives). The SC expects that most states will send their data via FTP or on CDs.

States are asked to comply with HIPAA Privacy and Security Rules, CMS Business Partners Systems Security Manual rules for sensitive data transfer, and their own state privacy and security rules. Any media that contains sensitive data must be labeled "CMS Sensitive Information." ***States must password-protect the data stored on the media.***

States should send electronic media via a private overnight delivery service (such as FedEx or UPS) or USPS and mark the envelope, "To be opened by addressee only." Data containing electronic personal health information (EPHI) cannot be emailed. Passwords and data documentation including file names, record layouts, and data definitions need to be sent to the SC by mail or email. ***Password information must be sent separately from the data.***

The SC will transmit data to states. The SC will password-protect and encrypt all datasets using the encryption option in zip software. If FFS sample data does not include electronic private health information (EPHI), it will be sent to states by email. Data with EPHI, including FFS full claims and Managed Care data, will be burned onto CDs and labeled "CMS Sensitive Information." CDs will be sent via FedEx and marked "To be opened by addressee only." In all instances, passwords will be sent separately. The SC will also send an email notifying the state that data has been sent to them and asking the state to verify that they received the data.