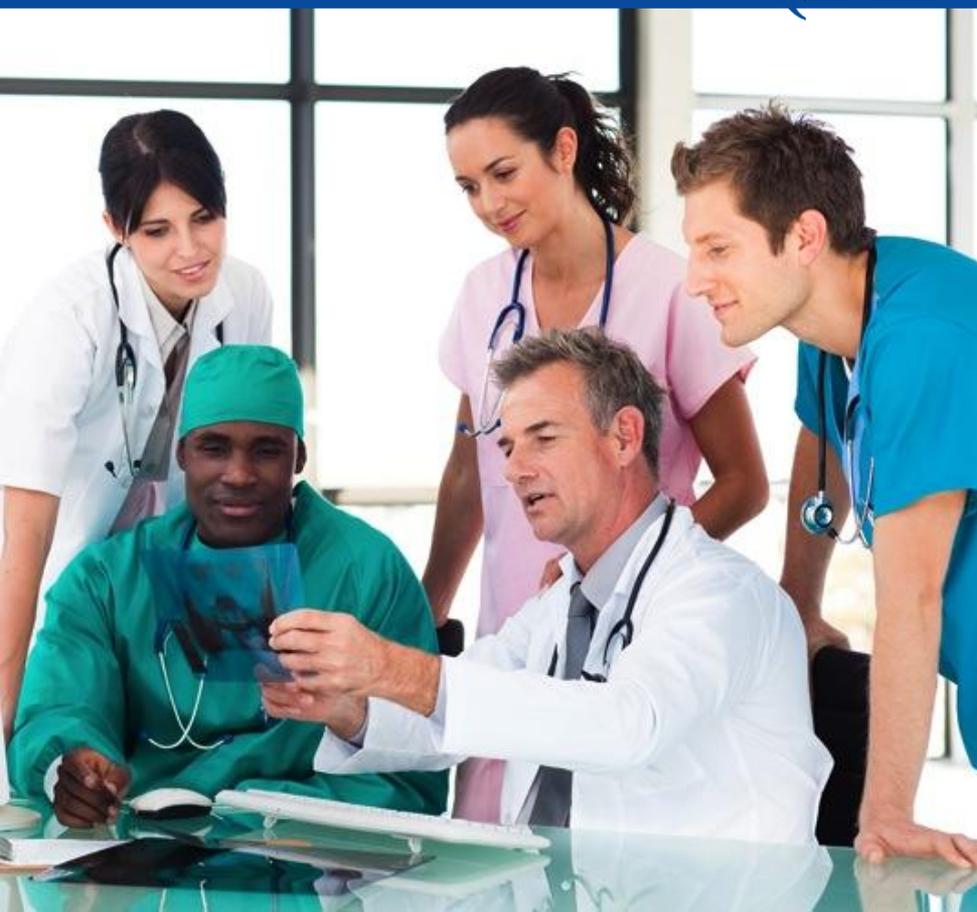


Payment Error Rate Measurement (PERM)



*FY 2015 Cycle
Kick-Off*

August 14, 2014

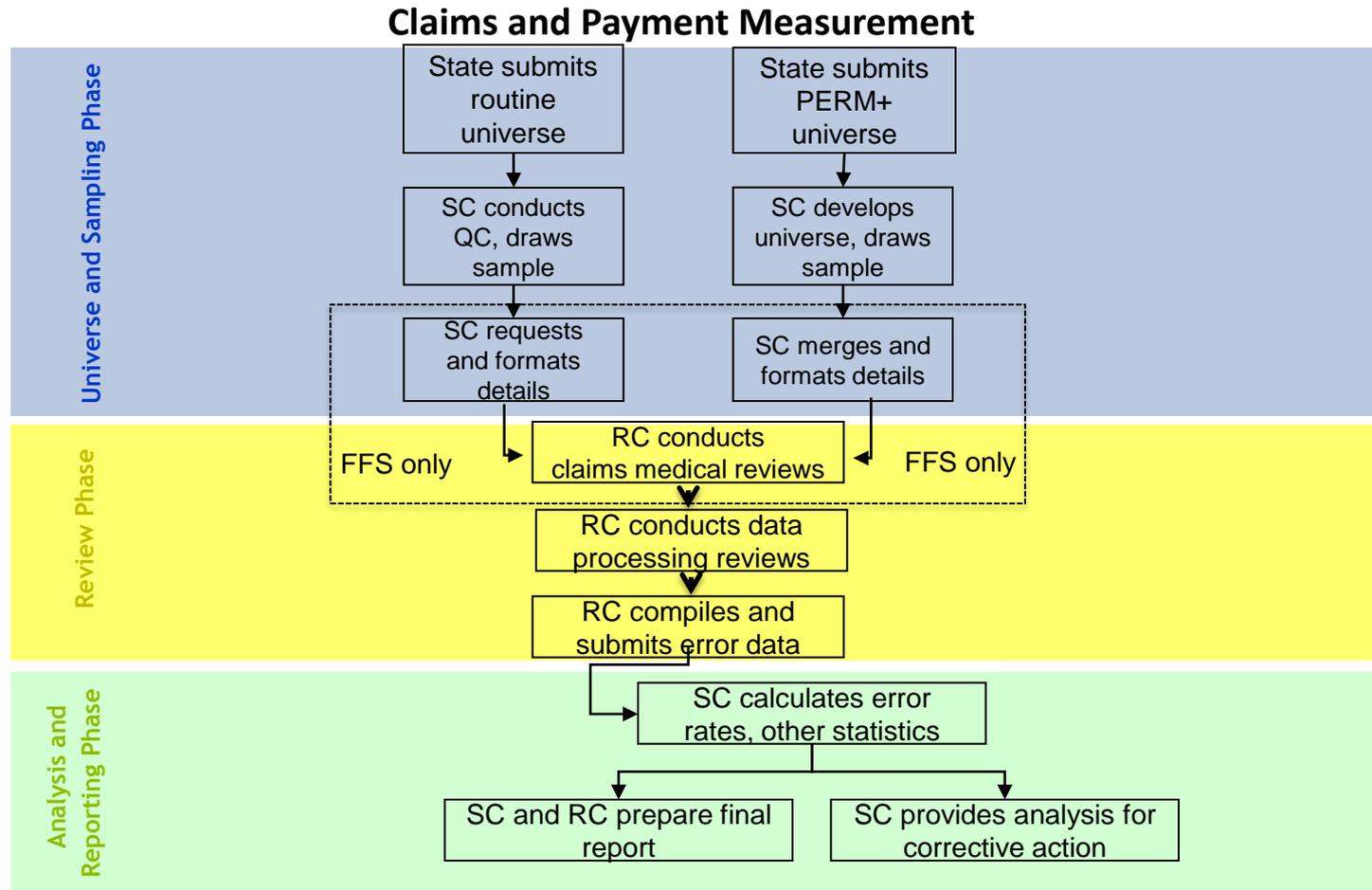
Objectives

- PERM Program Overview
- Claims Data Submission
- FFS and Managed Care Sampling
- FFS Details Data
- State Policy Collection
- Data Processing Reviews
- Medical Records Requests
- Medical Reviews
- Tracking Errors and Responding to Findings
- Error Rate Reporting
- Next Steps
- Communication and Collaboration
- Available Resources
- Contact Information

PERM Program Overview

- CMS is required to estimate the amount of improper payments in Medicaid and CHIP annually by the IPIA (now amended by IPERIA)
- Goal of PERM is to measure and report an unbiased estimate of the true error rate for Medicaid and CHIP
- Because it is impossible to verify the accuracy of every Medicaid and CHIP payment, CMS samples a small subset of payments for review and extrapolates the results to the “universe” of payments
- Currently operating under PERM final regulation published August 2010
- This cycle will review Medicaid and CHIP payments made in FY 2015 (October 1, 2014 through September 30, 2015)
- FY 2015 error rates will be reported in November 2016

PERM Program Overview



Claims Data Submission

- States must submit valid, complete, and accurate claim universes to the SC
- States have 2 data submission options—**must choose by September 15, 2014**
 - Routine PERM
 - PERM+
- Intake meeting held with each state to discuss:
 - Requirements of PERM claims data submission
 - Intake protocol questions (how Medicaid and CHIP programs are structured, what data sources will be used, what waiver programs operate in the state, etc.)

Claims Data Submission

- Claims data due dates

Quarter	Paid Date	Due Date
Quarter 1	October 1 – December 31, 2014	January 15, 2015
Quarter 2	January 1 – March 31, 2015	April 15, 2015
Quarter 3	April 1 – June 30, 2015	July 15, 2015
Quarter 4	July 1 – September 30, 2015	October 15, 2015

- Expect back and forth with SC about claims data
 - SC performs a series of quality control checks
 - Comparison of PERM data submission to CMS-64/21 reports

FFS and Managed Care Sampling

- ****New**** Stratification by four service types prior to pulling FFS samples
 - In FY 2012, the SC pulled from over ten service-specific strata
 - In FY 2015, the SC will select samples from four service-based strata, three payment-weighted strata and one denied/zero paid claim strata
 - SC will place claims into strata primarily using claim type and provider type
 - States will be asked to review the stratification before Quarter 1 data is processed to ensure all claims are being stratified correctly
- State-specific Medicaid and CHIP sample sizes based on FY 2012 results

FFS Details Data

- Details data used to request medical records and conduct medical review for sampled FFS claims
 - Submitted by routine PERM states
 - SC creates details file for PERM+ states
- As in FY 2012, the SC will hold details intake meetings with routine PERM states to
 - Provide an overview of the details data requirements
 - Discuss details intake protocol
- ****New**** Details intake meeting held with PERM+ states to
 - Review details built by the SC
 - Verify information to support medical record request
- SC performs a series of quality control checks and sends questions on any missing/incomplete/invalid information to the states

State Policy Collection

- The RC will collect state Medicaid and CHIP policies in order to conduct reviews
- Policies may include rules/regulations, manuals, handbooks, bulletins, updates, notices, clarifications, reminders, fee schedules, codes, etc.
- The RC will download all publically available state policy documents relevant to the medical review of claims and create a master policy list for each state
- The RC submits policy documentation to each state for review and approval:
 - Medical Review/Policy Questionnaire
 - Master policy list
- RC continues policy collection throughout the measurement and validates with state as appropriate

Data Processing Reviews

- Conducted on each sampled FFS and managed care payment
- Validates that the claim was processed correctly based on information found in the state's claims processing system
- Reviews can take place on-site at the state or remotely
- RC Educational Webinars are held with all states in the cycle to review the Data Processing (DP) review process before starting DP reviews
- Data Processing orientation is scheduled with each state prior to reviews
 - ****New**** States complete DP check list in preparation for DP reviews
 - Review state system(s) questionnaires
 - Review any special programs (waivers, etc.)
 - Demonstration of any new systems
 - Determine and gather desk aids, manuals, and website links needed for training DP reviewers
 - Discuss remote vs. on-site reviews and establish tentative dates to begin reviews
- ****New**** States track pending DP reviews through SMERF and receive automated notices for overdue pending information

Data Processing Reviews

DP Review Elements - Recipient

- Date of Death
- Date of Birth/Age
- County of Residence
- Gender
- Citizenship
- Living Arrangements
- Aid category
- Managed Care Enrollment
- Patient Liability (SOC), if applicable
- Medicare and/or other insurance
- ****New**** Eligibility Systems Verification

Data Processing Reviews

Verification of Provider Eligibility

For billing, servicing, and referring providers:

- Name
- NPI Number
- Active Enrollment
- Active License (if required)
- Active CLIA (if required)
- Type/specialty
- Service Location
- Sanctions
- Suspension Periods
- ****New**** OIG Exclusion List
- ****New**** Risk-based screening of newly enrolled providers
- ****New**** referring/ordering provider enrollment

Data Processing Reviews

Verification of Accurate Payment

- Determine whether claim filed timely
- Was claim for a covered service?
- Was claim priced accurately based on the Fee Schedule in affect for the Date of Service?
- Determine if claim is a duplicate of a previously paid claim
- Identify, report and consider any adjustments to the sampled payment made within 60 days of original payment

Data Processing Reviews

Miscellaneous Payment Information

- Prior Authorizations (PA) required under the state's policies
- View and compare scanned images of hard copy claims and attachments with system information
- Payments for "Sister Agencies" that receive pass-through Federal Financial Participation (FFP)

Data Processing Reviews

Managed Care Capitation Payment

- Recipient information
- Health Plan information
- Capitation Rates per Health Plan
- Geographic Service areas (county, zip code, etc.)
- Rate Cells
- Exclusions/Carve Outs
- Capitation Payment history screens
- Roll-Out dates (if staged implementation was in effect)
- Duplicate payment/adjustment check

Data Processing Reviews

FY 2015 PERM Data Processing Error Codes

DP 1 – Duplicate Claim	DP 8 – Managed Care Rate Cell Error **New**
DP 2 – Non-Covered Service/Recipient **New**	DP 9 – Paid Incorrect Managed Care Rate **New**
DP 3 – FFS Payment for a Managed Care Service	DP 10 – Provider Information/Enrollment Error **New**
DP 4 – Third-Party Liability Error	DP 11 – Claim Filed Untimely **New**
DP 5 – Pricing Error	DP 12 – Administrative/ Other Error
DP 6 – System Logic Edit Error	DTD – Data Processing Technical Deficiency
DP 7 – Data Entry Error	

Medical Records Requests

- Medical Record Request orientations are held for all cycle states, as part of the RC Educational Webinars, before requests begin to include:
 - Medical record request process
 - Medical record request questionnaire
- RC makes initial calls to providers to verify provider information
- RC sends record requests
 - Providers have **75 days** to submit documentation
- RC makes reminder calls and sends reminder letters on day 30, 45, and 60 until the record is received
 - If the provider does not respond, the RC sends a non-response letter on day 75

Medical Records Requests

- If submitted documentation insufficient, RC requests additional documentation
 - Provider has **14 days** to submit additional documentation
 - Reminder call and letter on day 7
- ****New**** Two additional letters sent to providers:
 - Receipt of Insufficient Documentation letter
 - Resubmission letter
- RC will accept and review late documentation (submitted past the 75 day and 14 day timeframe) until the cycle cut-off date (July 15, 2016)
- State involvement essential in obtaining necessary documentation
- CMS will host a series of interactive PERM Provider Education Webinars

Medical Reviews

- Conducted on sampled FFS claims
- Utilizes claims data submitted by states, records submitted by providers, and collected state policies
- Validates whether the claim was paid correctly by assessing the following:
 - Adherence to states' guidelines and policies related to the service type
 - Completeness of medical record documentation to substantiate the claim
 - Medical necessity of the service provided
 - Validation that the service was provided as ordered and billed
 - Claim was correctly coded
- Medical Review orientations are held for all cycle states, as part of the RC Educational Webinars, to include:
 - Medical review process
 - Difference Resolution/Appeals process
 - Medical review/policy questionnaire

Medical Reviews

FY 2015 PERM Medical Review Error Codes

MR 1 – No Documentation	MR 7 – Medically Unnecessary Service
MR 2 – Incomplete Documentation **New**	MR 8 – Policy Violation **New**
MR 3 – Procedure Coding Error	MR 9 – Inadequate Documentation **New**
MR 4 – Diagnosis Coding Error	MR10 – Administrative/ Other
MR 5 – Unbundling	MTD – Medical Technical Deficiency
MR 6 – Number of Unit(s) Error	

Tracking Errors and Responding to Findings

- State Medicaid Error Rate Findings (SMERF) system
 - Track medical records requests
 - Track medical and data processing reviews
 - Access SUD, Y-T-D Errors, and Recoveries reports
 - Request difference resolution and appeals
 - Access error rates and final findings
 - ****NEW**** SMERF 2.0 released
- SMERF system orientations are held for all states before records are requested or Data Processing and Medical Reviews are started
- States receive advanced notice of every DP and medical review error identified
- Errors officially reported to states through Sampling Unit Disposition (SUD) reports on the 15th and 30th of each month

Tracking Errors and Responding to Findings

- State has **20 business days** from the SUD report date to request difference resolution
 - **States must request difference resolution to re-price partial errors**
- States have **10 business days** from difference resolution decision to appeal error to CMS
- States are required to return the federal share of overpayments identified on sampled FFS and managed care payments
- States are required to develop a Corrective Action Plan to address each error

Next Steps

- **August 2014**
 - Complete universe data submission survey by **August 15**
 - FFS and managed care sample sizes verified by **August 31st**
- **September 2014**
 - Communicate decision between PERM+ and routine PERM by **September 15**
 - Data submission instructions distributed to states
 - ****NEW**** Referring provider name and NPI required in universe submissions
 - ****NEW**** Additional provider fields may also be added to support DP review
 - PERM General Education Webinars
 - Claims orientations/intake sessions begin

Next Steps

- **October – December 2014**
 - Alert Lewin no later than October 1 if DUA is needed for data submission
 - Claims orientation/intake sessions continue
 - Prepare for universe data submission
- **January 2015**
 - Q1 claims data due January 15

PERM Eligibility Component

- The FY 2015 cycle will **not** consist of an eligibility component.
- State-specific error rates will be calculated based on the FFS and managed care components.
 - No state-specific PERM eligibility error rates will be calculated
- At the national level, CMS will report comprehensive Medicaid and CHIP error rates based on the continuing FFS and managed care reviews and an estimated eligibility component error rate based on historical data
 - State eligibility error rates will be frozen at their last measured level to estimate the eligibility error rate
- Medicaid and CHIP Eligibility Review Pilots have replaced the PERM eligibility component and MEQC traditional pilots for FY 2014 – FY 2016
 - All states are required to conduct 4 Medicaid and CHIP eligibility review pilots over the 3 year period
- For more information please visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html
- Please submit any questions to the mailbox: FY2014-2016EligibilityPilots@cms.hhs.gov

Communication and Collaboration

- **FY 2015 PERM Cycle 1 Calls**
 - The cycle calls will occur on the second Thursday of each month from 2:30 – 3:30 pm Eastern Time
 - First cycle call will be held on Thursday, October 9, 2014
- **PERM Technical Advisory Group (TAG)**
 - Quarterly TAG calls as a forum to discuss PERM policy issues and recommendations to improve the program
 - Regional TAG reps
- **CMS PERM Website**
 - www.cms.gov/PERM

Available Resources

- **Provider Education PERM Initiative (PEPI) Workgroup**
- **PERM Manual**
- **PERM Standard Operating Procedures for state staff**
- **State Systems Workgroup**
- **Mini-PERMs**

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