



# PERM Newsletter

The Centers for Medicare & Medicaid Services



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Baltimore, MD 21244

## NEW CONTRACT AWARD!

CMS recently awarded the Eligibility Support Contract (ESC) to The Lewin Group.

The ESC will assist CMS in developing and testing new PERM and MEQC eligibility review guidance reflecting Affordable Care Act (ACA) requirements.

State participation is essential to this project. States may participate in the following ways:

- Stakeholder Interviews
- PERM model pilots



## In this issue:

New Letter to Providers	1
New Eligibility Support Contractor (ESC)	1
New Aspects of Data Processing Review	1
New Stratification in FY 2014	2
Eligibility Pilot Proposal Update	2
Overview of CMS's CAP Review Process	2

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## New Aspects of Data Processing

Under the Affordable Care Act, all providers must be screened under a risk-based screening process prior to enrollment and all referring/ordering providers must be enrolled with Medicaid or CHIP.

Review of referring/ordering provider requirement – referring/ordering provider information should be included on all claims and in the state systems prior to claims payment. Any claims that require a referring/ordering provider but were not screened for this requirement prior to payment will be cited as an error (unless one of the two exceptions is met). These errors will be for the full claim amount and categorized as Non-covered Service (DP2) errors.

Two exceptions are:

1. The state has a State Plan Amendment (SPA) that allows an exception to this requirement and the SPA covers the DOS.
2. The claim is an institutional claim that was filed prior to the correction to the UB form that allowed the insertion of referring provider information (July 1, 2012).

The PERM Review Contractor will look for referring/ordering providers on all claims that require an ordering/referring provider based on state policy, as well as for services that typically would not be provided without an order such as prescriptions, labs, radiology, and DME.

Implementation of risk-based screening of providers – the data processing review will confirm that providers who are newly enrolled or re-enrolled after March 24, 2011 (or after extension dates allowed by SPA) have been evaluated under the risk-based criteria in accordance with CMCS Informational Bulletin dated December 23, 2011. If the “new” provider was not evaluated under the risk-based process, and the reviewer is unable to confirm through the PECOS system that the provider was screened through the risk-based process by Medicare, a Non-covered Service (DP2) error will be cited for the full amount of the sampled payment. However, if the state conducted all screenings required under 42 CFR 424.518 but failed to assign a risk level, only a deficiency will be cited.

## New Letter to Providers:

Based on state feedback, CMS and the PERM Review Contractor developed an additional letter to send providers beginning with the FY 2014 PERM cycle.

Previously, if a provider responded to a PERM request for additional documentation and the documentation submitted was still insufficient, the provider would receive no notification.

The new “Receipt of Insufficient Information” letter will be sent to providers for any insufficient documentation (MR2) errors in which additional documentation was requested from a provider, the provider submitted additional documentation, and the documentation submitted was still insufficient. The new letter:

- notifies providers that the documentation received has been considered by medical review and is still insufficient to support the claim;
- provides a list of the missing documentation;
- informs providers that an error for insufficient documentation has been cited and that the state may pursue recovery; and
- clarifies that the Review Contractor will make no further requests for documentation but the provider may still submit the documentation.

# New Service Stratification in FY 2014

CMS is enhancing PERM's FFS service type stratification approach. Beginning with the FY 2014 PERM cycle, PERM will stratify by the four service types that have resulted in the largest amount of projected improper payments for each program. Each strata will then be further stratified by payment value. This new approach will result in more precise state-level error rates and better information for implementing corrective actions. The service strata are listed below:

**HCBS/Hospice/Rehab (Medicaid and CHIP):** Long-term care support services provided to members in the community, hospice services, and services provided by rehabilitation centers on an outpatient basis. Claims submitted by the following claim/provider types are included:

- Home health agencies
- Hospices
- Waiver services
- Assisted living
- Home delivered meals
- Personal care
- Attendant care
- Rehabilitation center services billed on an outpatient or medical claim type

**Physician, Dentists, and Other Practitioners (Medicaid and CHIP)** – Medical services provided by physicians and other health care professionals, outside of a clinic setting. Claims submitted by the following claim/provider types are included:

- Primary care physicians
- Specialty physicians
- Psychiatrists and mental health providers
- Dentists
- Physician assistants and nurse practitioners
- Optometrists and opticians
- Other licensed health care professionals

**Pharmacy (Medicaid and CHIP)** – Prescription drugs and other medical supplies dispensed by pharmacies in the community. Claims submitted by independent pharmacies are included.

**Long-Term Care (Medicaid Only)** – Long-term care services and rehabilitation services provided to members at long-term care institutions. Claims submitted by the following claim/provider types are included:

- Nursing home facilities
- Intermediate care facilities – MR
- Rehabilitation hospitals
- Residential treatment centers

**Inpatient Hospital (CHIP Only)** – Claims for services provided to members on an inpatient basis. Claims submitted by the following claim/provider types are included in this category:

- Short-term general hospitals
- Psychiatric hospitals
- Alcohol and substance abuse hospitals

The physician cost component of inpatient hospital services, when the services were billed on an inpatient claim type

**Denied and Zero Paid (Medicaid and CHIP)** – Stratum will include all denied claims and all claims with a payment status of “paid” and a paid amount of \$0.

**Other (Medicaid and CHIP)** – All FFS claims that do not fall into one of the strata listed above.

Restricting the number of stratified service types to four provides greater flexibility of the design from state to state. A minimum sample size is set for each stratum. After allocation of minimum sample sizes for each stratum, the rest of the quarterly sample will be allocated in proportion to the payment size for each stratum for each quarter.

## New Features on cms.gov/PERM!

We updated our webpage and added tabs:

- PERM Error Rate Findings and Reports
- Corrective Action Plan (CAP) Process
- Providers
- FY 2014-FY2016 Eligibility Review Pilots

Updated documents:

- PERM manual
- PERM overview slides



## Overview of CMS' CAP Review Process

CMS uses a two-stage process when reviewing state PERM CAPs.

**Stage 1: Initial Review**—The state's CMS PERM CAP liaison completes a check list to ensure the state CAP contains all required elements. This review ensures a CAP is present for each component of each program, that the state has addressed every error (including deficiencies), and that the appropriate data analysis, program analysis, corrective action planning, implementation and monitoring, and evaluation are present.

If the CAP doesn't pass the initial review, the state receives a letter listing the items missing from the CAP. Once the CAP contains all required elements, the state receives a letter stating as such and the CAP moves on to stage 2.

**Stage 2: Collaborative Review**—The state's CAP is distributed to multiple CMS parties for further review. The CMS PERM team,

federal PERM contractors, CMS Medicaid Integrity Group, and CMS Regional Office review the corrective actions to evaluate their ability to reduce improper payments.

Comments/questions/feedback on the state's CAP are consolidated by the PERM CAP liaison and sent to the state for discussion on their post-CAP webinar.



## Eligibility Pilot Proposal Update:

CMS continues to work with States on the 1st Round of Eligibility Pilot Proposals. Most of the States Pilot Proposals are nearing completion. If any state has questions please email the CMS mailbox:

FY2014-2016EligibilityPilots@cms.hhs.gov

## Upcoming Calls:

PERM TAG call- April 24, 2014

FY 2013 PERM Cycle Call– April 24, 2014, 2-3pm EST

FY 2014 PERM Cycle Call–May 6, 2014 2014, 3-4pm EST