Payment Error Rate Measurement (PERM)

PERM Overview for Providers

Presented by:

Payment Accuracy & Reporting Group
Office of Financial Management
Centers for Medicare & Medicaid Services

Overview

- The PERM program is designed to measure improper payments in the Medicaid and CHIP programs.
- During each PERM Cycle, CMS hosts multiple provider education sessions which are presented on webinar/conference call platforms.
- The purpose is to provide opportunities for the providers of the Medicaid and Children's Health Insurance Program (CHIP) communities to enhance their understanding of specific Provider responsibilities during the PERM cycle.
- You will have the opportunity to ask questions live during the Q&A portion of the conference calls, via the webinar, and through the dedicated PERM Provider email address at: PERMProviders@cms.hhs.gov

PERM Background

The Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), requires the heads of federal agencies to annually review programs that they administer to:

PERM Background

- Conduct annual reviews of programs they administer.
- Identify those that may be susceptible to significant improper payments.
- Estimate the amount of improper payments.
- Submit those estimates to Congress.
- Submit a report on corrective actions the agency is taking to reduce improper payments.

PERM Background

The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. As a result, CMS developed the Payment Error Rate Measurement (PERM) program to comply with the IPIA , IPERA, IPERIA and related guidance issued by OMB.

- The PERM program measures improper payments in Medicaid and CHIP and produces improper payment rates for each program
- Improper payment rates are based on reviews of fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the Fiscal Year (FY) under review
- The improper payment rate is not a “fraud rate”, but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements
- CMS and HHS report improper payments annually in the Agency Financial Report (AFR), located at http://www.hhs.gov/afr/

How is the PERM performed?

CMS uses a 17-state rotation for PERM. Each state is reviewed once every three years.

- The measurement cycles are:
  - **Cycle 1** - Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming.
  - **Cycle 2** - Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia.
  - **Cycle 3** - Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington.

How is the PERM performed?

- CMS conducts a medical record review of FFS payments to determine the appropriateness of the payment.

- Not every provider will be contacted to provide medical documentation; only those providers that provided services for the random sample of FFS claims selected.
  - The random sample is pulled from all Medicaid and CHIP FFS payments a state makes in a federal fiscal year.

- Medical records are requested from the provider by the PERM Review Contractor for all FFS claims in the sample.

- CNI Advantage is the current PERM Review Contractor.

The Medical Record/Documentation Requests

- Customer Service Representatives (CSRs) will call all providers in the sample to describe the purpose of the call, explain the authority for CMS to collect medical records for audit purposes, and identify the appropriate point of contact for each provider.

- CSRs will identify which patient's record is needed for review for a specific date of service that matches the provider's claim.

- After confirming that the correct provider has been reached and the location of the medical record needed, a written request will be faxed or mailed to the provider's office.

The Medical Record/Documentation Requests

- The request will specify the type of documents needed for each claim type and will provide instructions for how to submit records to the PERM Review Contractor by fax (please number all pages), mail, a password protected CD, or the electronic submission of Medical Documentation (esMD).

  - For information about esMD, please visit https://www.cms.gov/ and search for esMD for more information
  - For sample documents visit https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index.html?redirect=/PERM
    - Select “Providers” from the menu. Documents include:
      - Initial Request Letter
      - Claim Category Matrix – a documentation guide
      - Frequently asked questions
      - List of PERM State Liaisons

Timeframes (Initial)

- The current PERM cycle is reviewing Medicaid and CHIP FFS payments made by states October 1, 2015 – September 30, 2016
- Requests for provider medical records associated with the sampled FFS claims will begin in May/June 2016 and will continue through July 2017.
- Providers will have 75 calendar days from the date of the request letter to submit the record to CNI.
- During this 75 calendar day period, CNI will conduct reminder phone calls and send written requests to providers if records are not received.
- Once records are received, this 75 day timeframe will expire.

Timeframes (Additional information requests)

- If documentation in the record submitted is incomplete to support the claim, CNI will request additional documentation before the review is completed. Providers will then have 14 calendar days from the date of the request letter to submit this documentation.

- Your state contact is notified when documentation is submitted, or has not been received timely.

Importance of submitting complete patient records

Errors: All claims with no documentation or incomplete documentation from the provider will be determined to be paid in error.

Sanctions: If a claim is determined to be in error, State Medicaid Agencies may pursue recovery of payment for this claim.

Appeals: The normal state appeal rights apply to each claim.

Importance of provider documentation

- Accurate PERM measurements cannot be produced without provider cooperation in submitting documentation.

- A correct finding of proper payment cannot be made without the medical record from the provider.

- All records are equally important, even those for low dollar claims.

PERM Contact Information for Providers

CMS PERM Website

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index.html?redirect=/PERM

The “providers” page helps to better understand the PERM process and what you may be required to do during a review. Select **“Providers”** from the menu on the left side of the page.

PERM Email Address for Providers:

PERMProviders@cms.hhs.gov