PERM SC FAST FACTS FOR CLAIM ADJUSTMENTS

What are claim adjustments?

Adjustments are modifications made to claims after the initial submission (original payment). An original payment reflects what the state initially paid out for the claim before any corrections, reversals, or adjustments were made. For example, if a provider bills Medicaid for $200 for an office visit and the state processes the claim and pays $150, the $150 paid amount represents the original payment for the claim. Any changes made to the $150 payment amount after its initial adjudication would represent an adjustment. Adjustments can occur for many reasons, but most often are used to update incorrect information which was submitted on the initial claim (HCPCS/CPT/NDC code, number of units, amount billed, etc.). The adjustment corrects the claim information and the claim then reprocesses through the system. Since the Payment Error Rate Measurement (PERM) universe contains only **original** Medicaid and Children's Health Insurance Program (CHIP) service claims and payments that are fully adjudicated by the state each quarter, states are required to either remove all adjusted claims ahead of universe data submission (routine PERM) or provide logic to identify adjusted claims so that the Statistical Contractor (SC) can remove them when building the universe (PERM Plus). Removing adjusted claims prior to sampling ensures that each claim has only one chance of being sampled.

How are adjustments identified in state data?

The SC asks how to identify adjustments during the Intake Meetings at the beginning of the cycle. While it can vary from state to state, adjustments are typically identified by an adjustment indicator or the claim Internal Control Number (ICN). ICNs of adjusted claims usually end in a number other than one and are tied to the original claim (e.g., original claim ends with digits '001' and the adjusted claim ends with the digits '002').

Are there types of adjustments that are more difficult to identify in state data?

While most adjustments are typically easy for states to identify using specific fields (adjustment indicator, ICN, etc.), some can be more challenging since they may not be reflected in the system the same way. Three non-typical adjustments states have struggled to identify in PERM have been:

- Managed care rate adjustments – Managed care rate adjustments are modifications made to capitation rates in managed care plans to account for various factors that affect the cost and quality of care.[1] If the rate adjustment occurs months/years after the initial capitation payment, then it can be difficult for the states to identify them as an adjustment to a previous payment. In these cases, the SC would only want to review the original capitation made for the coverage period. Beginning in RY 2026, the SC requested submission of the Capitation Reason Code field in the state universe data to more easily identify rate adjustments.
- Void and replace – A voided claim is one that has been cancelled after submission. A replacement claim is typically submitted after a claim is voided and contains updated information about the beneficiary, provider, and/or service(s). Voided claims are not reviewable. States should remove voided claims prior to universe data submission (routine PERM) or provide logic for the SC to remove them from the sampling universe (PERM Plus).
- Point of Sale (POS) reversals – Pharmacy claims are typically transmitted using a POS system. The POS systems allow for multiple iterations of claims to be submitted. Most of the POS claims are reversed after

[1] 2024-2025 Medicaid Managed Care Rate Development Guide

submission and one version processes through for payment. If state systems store all iterations of a claim submitted using a POS system, the SC should be provided with logic to remove all versions of the claim except for the one that fully adjudicated (either paid or denied). Including all iterations from a POS system will artificially inflate the number of pharmacy claims included in the sampling universe and impact the state's Forms CMS 64/21 reconciliation during the cycle.

What are some best practices for identifying these adjustments in state data?

Three suggested identification methodologies include:

- Managed care rate adjustments – Check with the state managed care team to identify dates when mass rate adjustments were processed. Often, these rate adjustments are processed on a different timeline than regular capitation payments (e.g., capitations pay on the 5th of the month and adjustments process through on the 15th of the month). Note that different types of capitation payments may have different payment dates (e.g., retroactive eligibility, delivery payments, etc.). If your managed care staff is able to provide dates when adjustments were processed, send those dates to the SC so that the payments may be removed from the sampling universe.
- Void and replace claims – Determine how voids are identified in state data and either remove them ahead of submission or provide logic to the SC for removal. Void identification logic will be requested during both the intake meeting and universe build/payment level meetings so that the SC can confirm these claims are not included in the sampling universe.
- POS reversals – Have staff familiar with pharmacy claims/payments provide logic to identify paid claims versus claims that were submitted and then reversed. Notify the SC about your state's use of a POS system so that early comparisons can be done on your state's Forms CMS 64/21 data to determine if it appears that reversals have been included in the universe data.

For more information about claims submission and adjustments, please refer to the resources available on the CMS PERM website:

- Data Submission Instructions – Once on the site, states should choose their cycle from the menu on the left of the screen to see documents appropriate to their cycle.
- Data Submission Best Practices – Once on the site, states should choose State Resources from the menu on the left of the screen and then scroll down to this document.

What is the impact of adjustments being included in the sampling universe?

When data is submitted or sampled incorrectly it creates issues across the cycle. Claims may need to be dropped from review, meaning that any work done on those claims by the state and contractors would be discarded. Depending on the number of claims that need to be dropped, oversamples might need to be drawn. This can create extra work for states and contractors late in the cycle.