CENTERS FOR MEDICARE & MEDICAID SERVICES

PERM RC Data Processing Review Orientation

RY26 Cycle 2 States

Empower AI

Payment Error Rate Measurement (PERM)

Review Contractor (RC)

Agenda

- Data Processing (DP) Review Basics.
- DP Claim Review Elements.
- State Responsibilities.
- Lessons Learned.
- Difference Resolution (DR) and Appeals.
- Contact Information.

Learning Objectives

- Following this webinar, participants should be able to:
  - Describe the basic elements of a DP review.
  - Identify state responsibilities in supporting DP reviews.
  - Describe the DR and appeals processes and timelines.
  - Contact the RC and CMS PERM State Liaisons if needed.

DP Review Basics

- The PERM RC conducts DP reviews on each sampled fee-for-service (FFS) and managed care payment to validate that the claim was processed correctly based on information found in the state's claim processing systems, contracted vendor claim processing systems, and other supporting documentation maintained by the state.

Claim Review Elements

- Remote access to the state's claims payment system(s) and contracted vendor payment systems are required to complete DP reviews.
- All elements are not available in all systems (e.g., waiver claim payments, Pharmacy Benefit Manager [PBM], etc.).

DP Review Elements:

- ✓ Beneficiary information.
- ✓ Third-Party Liability (TPL) information.
- ✓ Provider information.
- ✓ Accurate claim payment.
- ✓ Managed care capitation payment.

Verifying Beneficiary Information

- To determine whether the beneficiary was eligible for payment of the services on the sampled claim, DP reviewers will verify the following information in the financial or other state systems is accurate:
  - Date of birth/age.
  - Date of death.‡
  - Citizenship status.
  - City/zip code.*
  - County of residence.
  - Gender.
  - Beneficiary ID.
  - Living arrangements.†
  - Patient liability/level of care.‡
  - Managed care/health plan enrollment.
  - Aid category, program eligibility, applicable waivers, and effective dates (relative to sampled date of service [DOS]).

** If needed to determine managed care status.*

† Home health, nursing facility, group home, other.

‡ If applicable.

Verifying Third Party Liability (TPL) Information

- The RC needs to determine whether TPL was available to cover the service and, if so, was considered in accordance with the state's TPL policy and federal regulations including the following:
  - Medicare eligibility (Parts A, B, and D with dates of eligibility).
  - Other TPL information, including coverage dates and covered services.

Verifying Provider Information

- The RC will determine whether all required provider(s) (billing/ attending/ rendering/ servicing, and ordering/ referring/ prescribing) were enrolled, as required, and eligible to provide and bill for the services under review:
  - Provider name.
  - National Provider Identifier (NPI).
  - Registration/enrollment.
  - Provider license.*
  - Clinical Laboratory Improvement Amendments (CLIA) certification.*
  - Provider type and specialty.
  - Provider and service location.
  - Provider sanction/ suspension periods.
  - Office of Inspector General/List of Excluded Individuals and Entities (OIG/LEIE) verification. RC also performs independent OIG/LEIE check.
  - Compliance with Affordable Care Act (ACA) risk-based criteria for provider enrollment/revalidation.

**If required.*

Provider Enrollment and Risk-Based Screening (RBS) Requirements

- All ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan must be enrolled as per federal regulation 42 CFR § 455.410.
- All enrolled providers must be risk-based screened appropriately per 42 CFR § 455.410, 42 CFR § 455.436, and 42 CFR § 455.450.
- Documentation required for screening:
  - Must be able to identify the provider being checked.
  - Must document the databases checked.
  - Must document the result of the check (pass/fail).
  - Must record the date of the check.
- **Note:** Reviewers will look for the effective date of the enrollment to determine whether a provider was enrolled on the DOS and will look to ensure all the screening requirements were met prior to payment of the claim under review.

Provider Enrollment and RBS Requirements

Databases for an Individual
National Plan and Provider Enumeration System (NPPES)
OIG LEIE
System for Award Management / Excluded Parties List System (SAM EPLS)
Social Security Administration's Death Master File (SSA DMF)

Databases for an Organization
NPPES
OIG LEIE
SAM EPLS

RBS Requirements: Negative Checks

- For efficiency, some states automate database checks.
- Performing a database check and only recording the result when a match is found in a particular database (i.e., not recording the result when no match is found) is referred to as a "negative check."
  - Negative checks are common for states working with a vendor or with automated database checks, but negative checks **do not** meet documentation standards.
- The RC will cite a DP10* error if all elements required for the database checks have not been performed and/or the state or vendor cannot provide documentation of the check.
- States are encouraged to work with the RC during the RBS Assessment process regarding any negative check method the state uses to determine available documentation and next steps.

*Click the link to view the slide with DP error code definitions.

Provider NPI Requirements for Provider Information

- A Type 1 NPI is assigned for healthcare providers who are individuals, including physicians, dentists, and sole proprietors.
- A Type 2 NPI is assigned to an organization, such as physician groups, hospitals, nursing homes, etc.
- All referring or ordering providers must have their individual Type 1 NPI listed on any claim for services requiring an order in accordance with 42 CFR § 455.440 and must be actively enrolled as a participating provider on the DOS of the claim in accordance with 42 CFR § 455.410(b).

Verifying FFS Payments

- DP reviewers determine whether payments are for covered services and that the payments are accurately calculated.
- To ensure these two requirements are met, DP reviewers will verify:
  - Timely filing requirements.
  - Reference screens with service parameters.*
  - Service coverage determination.
  - Reference screens with rates.†
  - Prior authorization requirements.
  - Prior authorizations issued.‡

* *National Drug Code (NDC), procedure codes, revenue codes, etc.*

† *Diagnosis Related Group (DRG), NDC, per diem, provider contract, procedure codes, revenue codes, Relative Value Unit (RVU), discounts, dispensing fees, etc.*

‡ *Service codes, effective dates, units, rates, etc.*

Verifying FFS Payments, continued

- DP reviewers will:
  - Calculate each sampled payment manually to determine if the payment was made in accordance with published state policies and rates in effect for the DOS under review.
- DP reviewers will need:
  - Access to the rates that were in effect for the DOS for claims under review.

Does the state make retroactive rate adjustments?

Verifying FFS Payments, continued 2

- DP reviewers will also need:
  - Information about how the state calculates each type of payment.
    - Rounding or truncating at each step or at the final step.
    - Applicable fees or co-pays.
    - Discount amount for the drug or provider.
    - The pricing method used for prescription payment (e.g., Average Wholesale Price [AWP], Federal Upper Limit [FUL], Maximum Allowable Cost [MAC]).
  - The ability to complete a duplicate check to ensure the same service was not paid more than once or to multiple providers for the same DOS, 30 calendar days prior to the claim payment date, and 60 calendar days after the claim payment date.

Verifying FFS Payments, continued 3

- DP reviewers need the following from the state:
  - Hard copy paper claims, or the ability to view the scanned image of the paper claim, to verify accurate transfer of information to the payment system.
  - Access or ability to view any adjustments made to the original sampled claim 60 calendar days after the date of payment.
  - Access to value code tables or a data dictionary of codes used in the system if not contained in system help.

Reviewing Managed Care Capitation Payments

- DP reviewers will also need access to:
  - Capitation rates.
  - Capitation payment history screens.
  - Geographical service areas (counties, zip code).
  - Managed care contract for sampled claims.
  - Population carve-outs.
  - Service carve-outs.
  - Rate cells.

Pending Review Completion Timeframes

- States will receive requests from the RC DP reviewers for information or documentation via the DP Pending P1 Lists.

DP Pending P1 List Process

- Current DP Pending P1 Lists are available in real time through the State Medicaid Error Rate Findings (SMERF) system state portal.
- The RC will notify the state DP contacts designated in SMERF via PERM alert emails of any questions or missing information needed to complete DP reviews.
- The state has two calendar weeks to provide the requested information to the RC.
- If the requested documentation is not received timely, the RC will complete the review with existing documentation and cite errors as applicable.
- The RC will provide updates on the DP Pending P1 List during RC check-in calls with states.

What is a DP Error?

A DP Error...

- Must affect payment to be considered a PERM error.
- Is determined from the claim information and other information in the state's payment systems, state regulations and policies, and federal regulations, policies, and laws.
- Is an overpayment or underpayment that could be avoided through the changes to the state's claims processing systems and/or operational procedures.
- Does not require clinical judgment.
- Does not require detailed analysis of beneficiary eligibility criteria.
- May be due to lack of information verifying the accuracy of a payment.

Preliminary DP Finding Codes

Code	Definition	Code	Definition
C1	Correctly Paid	P1	Pending Information From State
DP1	Duplicate Claim Error	DP8	Managed Care Rate Cell Error
DP2	Non-Covered Service/Beneficiary Error	DP9	Managed Care Payment Error
DP3	FFS Payment for a Managed Care Service Error	DP10	Provider Information/Enrollment Error
DP4	Third-Party Liability Error	DP11	Claim Filed Untimely Error
DP5	Pricing Error	DP12	Administrative/Other Error

- Technical deficiencies were removed for all PERM review types because they do not result in payment errors.

State Responsibilities: Preparation for DP Reviews

- Work with state SMEs to complete the DP Questionnaire and RBS Assessment and ensure state SMEs attend the DP Questionnaire and RBS Assessment Webinar to discuss state responses.
- States prepare to grant state system access to the RC DP reviewers during the pre-cycle phase:
  - Identify and address specific state concerns regarding access.
  - Request security access forms from state IT staff for DP reviewers' read-only access to the Medicaid Management Information System (MMIS) and other payment systems.
  - Obtain business partner agreements, if needed by the state or state vendor, e.g., Data Use Agreements (DUA), Business Associate Agreements (BAA), etc.

State Responsibilities: Preparation for DP Reviews, continued

- States also perform the following during the pre-cycle phase to prepare to grant state system access to the RC DP reviewers:
  - Complete and return the DP State Systems Questionnaire to the RC to:
    - Establish IT point-of-contact and communication protocol for remote users.
    - Determine specified means to access state systems (e.g., browser interface or through a client access software program).
  - Provide the RC with necessary software and coordinate to establish secure connectivity.
  - Establish user IDs and passwords for DP review staff.

State Responsibilities: DP Collaboration Meetings

- States actively participate in meetings with the RC:
  - **Orientation and Collaboration**: Review completed questionnaire and data inventory for completeness and clarity prior to returning to the RC. Ensure appropriate state attendees (state PERM representative, program Subject Matter Experts [SMEs], and Information Technology [IT] representatives) attend the RC's DP Webinar with the state to be held in January/February 2025.
  - **Bi-weekly Check-in Calls**: Identify and address specific state concerns related to technology, process, and reporting prior to each call. Ensure appropriate state attendees (state PERM representative and SMEs) are invited to the calls. The RC will begin bi-weekly check-in calls with the state when the RC starts reviews for the state.

State Responsibilities: During DP Reviews

- During reviews, the state will need to:
  - Ensure SMEs are available to attend scheduled check-in calls when topics for their areas are added to agenda.
  - Review the DP Pending P1 List daily; follow up with SMEs to obtain answers. Provide any supporting documentation requested within two weeks to clear pending reviews on the DP Pending P1 List.
  - Coordinate with IT to resolve any access issues encountered by the review team.
  - Ensure the state PERM representative or appropriate designee is available to the RC State Lead Reviewer via email.
- As reviews are completed, the state will need to:
  - Answer any outstanding questions from the reviews.
  - Monitor Sampling Unit Disposition (SUD) reports and advance notification of error PERM alerts.
  - File DRs and appeals, if applicable.

Lessons Learned from DP Reviews

Issue #1	**DP reviewers don't always receive claim-specific information from the state.**
Resolution	**Documentation to support the state response must always accompany the explanation.**

- Examples of documentation include state or federal policy, screen prints from the state system, and/or the audit trail to show system changes that occurred after the claim was processed (particularly important for retroactive eligibility or retroactive rate changes).
- Documentation provided should reflect what was in effect on the sampled DOS.
- Refer to the RC DP State Lead when clarifications on questions or requests are needed.

Lessons Learned from DP Reviews, continued

Issue #2	**Non-responsiveness from states on DP Pending P1 List information requests frequently causes delays.**
Resolution	**All pending questions have a response deadline (14 calendar days from receipt).**

- If the state is unable to meet the deadline, communicate the reason for the delay and the expected submission date to the RC DP State Lead.
- **Note:** Reviews not addressed by the state within 14 calendar days will be cited as errors as the RC is missing documentation to support the payment. The list updates frequently. Best practice is to check the list daily and communicate with the RC and your CMS PERM State Liaison if you are unsure whether documentation was received.

Lessons Learned from DP Reviews, continued 2

Issue #3	**There are no indicators in the payment system of provider RBS verification.**
Resolution	**States should be prepared to provide documentation demonstrating all database checks, site visits, and Fingerprint-Based Criminal Background Checks (FCBC) required under ACA were completed based on the risk level of the provider under review.**

Lessons Learned from DP Reviews, continued 3

Issue #4	**Pricing documentation is maintained outside of MMIS, or rate information from vendors is not available.**
Resolution	**States should gather pricing information contained outside of MMIS and provide it to the RC during the pre-cycle phase to expedite the processing of DP reviews.**

Lessons Learned from DP Reviews, continued 4

Issue #5	**The RC lacks access to managed care contracts.**
Resolution	**States should gather the managed care contracts and deliver them to the RC during the pre-cycle phase. Please include rate information for managed care reviews.**

DR Request Overview

- DR is the first step for a state to dispute an error finding cited on DP reviews. A review may have more than one error finding to dispute. If a state disagrees with an error finding and has factually based evidence to support that the payment is accurate, the state may request a DR within SMERF.
  - Federal regulation 42 CFR § 431.998 requires that states have a factual basis for filing the request and be able to provide evidence directly related to the finding(s) to support their position.
- All DP review errors are eligible for DR, including multiple errors per claim.
- A state must request a DR on an error within 25 business days after the RC publishes the finding on the SUD report. SUD reports publish on the 15th and 30th of each month.
  - Business days exclude weekends and federal holidays.
- The RC will post the DR decision to SMERF and will notify states via email that the DR decision is available for review (this notification also describes the state's appeal rights).

DR Request Considerations

- A DR should be requested when the state:
  - Disagrees with the error finding and has a factual basis for filing the request along with valid evidence directly related to the finding(s) to support the state's position.
  - Has located additional information it would like the RC to consider.
- States must include the reason for requesting a DR and/or appeal in SMERF, rather than just stating that the documentation was submitted.

If you agree with the error finding(s), take no action; the findings will drop from the list of claims available to DR in 25 business days.

Filing a DR Request

- A state must file all DR requests in SMERF regardless of review type.
- A state can first identify errors finalized in SMERF through advance error notifications available in SMERF and sent to state contacts through PERM alert emails. This allows a state additional time to review and research errors prior to their publication on the SUD report.
- **Change from the RY23 cycle** If a review has multiple error findings, the state must request DRs and appeals separately for each finding. This allows each finding to move through the process independently.
  - For example, a DP review may have two findings, a DP10 and a DP5 error. The new functionality allows the state to file a DR on the DP10 error on the 10th day after the SUD report and then file a separate DR for the DP5 on the 20th day after the SUD report. The state could also file DRs for both errors on the same day.
  - Note: The timeframe to request a DR remains as 25 business days from the SUD posting. Business days exclude weekends and federal holidays.

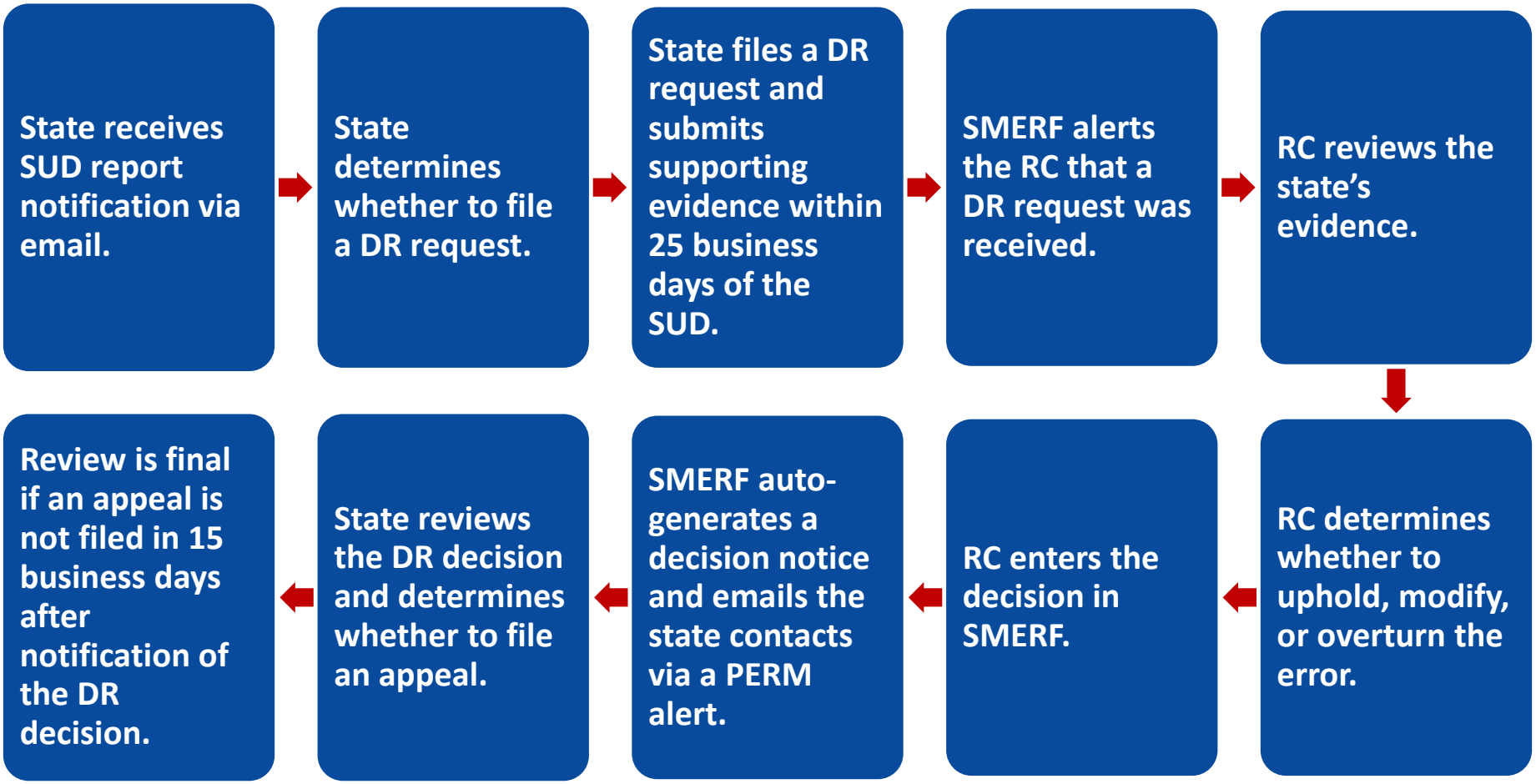
Filing a DR Request, continued

- To file a DR Request:
  - File the request in SMERF from the cases available for DR list. Note: The DR function does not appear in SMERF until the finding is published on the SUD report.
  - Submit supporting DP documentation to the RC via the RC's SFTP account (Kiteworks), secure email, fax, or mail.
  - Clearly identify the PERM ID on the submitted documentation.

Do not enter Protected Health Information (PHI) or Personally Identifiable Information (PII) into SMERF.

- If a state does not file a DR request within 25 business days of the finding posting to SUD, the finding is considered final.

DR Request Process



Appeal Request Overview

- The state must first dispute the PERM error finding through the DR process. If the DR results in the error being upheld or modified, the state may file an appeal.
- The state must file the appeal through SMERF within 15 business days from the date the RC posted the DR decision.
  - Business days exclude weekends and federal holidays.
- The state must submit all documentation or evidence relevant to the appeal at the time the appeal is requested per federal regulation 42 CFR § 431.998.
  - Submit supporting DP documentation to the RC via the RC's SFTP account (Kiteworks), secure email, fax, or mail.
  - Clearly identify the PERM ID on the submitted documentation.
  - Do not enter PHI or PII in SMERF.

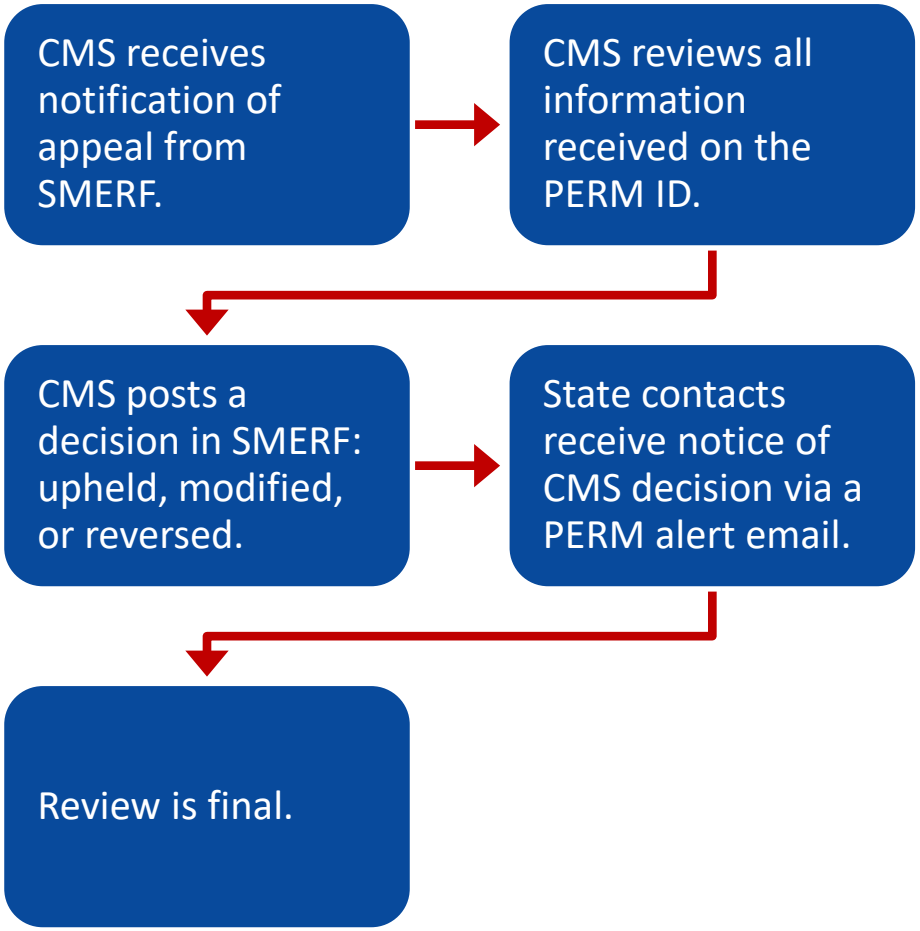
Appeal Request Overview, continued

- The state must be able to demonstrate all the following:
  - The factual basis for the state's appeal.
  - Provide valid evidence directly related to the finding(s) to support the state's position.
- If the state provides new documentation when the state files the appeal, the RC will review the documentation to determine if it warrants a change to the RC's decision without sending the appeal to CMS.
- If the documentation is not new or cannot be used to overturn the decision, the RC will notify CMS of the appeal pending with CMS.

Appeal Request Overview, continued 2

- CMS convenes a panel of PERM and policy experts to review appeals. CMS or the RC will contact the state if CMS has questions or needs additional information from the state in support of the appeal.
- Once CMS issues a decision, the state will receive a PERM alert email that the appeal decision is available for review in SMERF.
- The CMS review panel's decision is final and binding on states, as it is not reversible and marks the final step in the dispute process.

Appeal Request Process



- CMS reviews the following information when considering the state's appeal:
  - Claim detail.
  - RC original decision.
  - State DR request including factual basis and supporting evidence.
  - RC DR decision.
  - State appeal request including factual basis and supporting evidence.

RC Contact Information

Name/Title	Phone/Email
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Closing Remarks and Questions

Thank you for participating!