CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Payment Error Rate Measurement (PERM)

RY26 Medical Record Request (MRR) & Medical Review (MR) Processes

Empower AI

PERM Review Contractor (RC)

Agenda

- Introduction to MR.
- MRR Process Overview.
- MRR Letters.
- SMERF Resources for MRR.
- MR Process Overview.
- SMERF Resources for MR.
- Difference Resolutions (DRs) and Appeals.
- State Best Practices.
- Contacts.

What is a PERM MR?

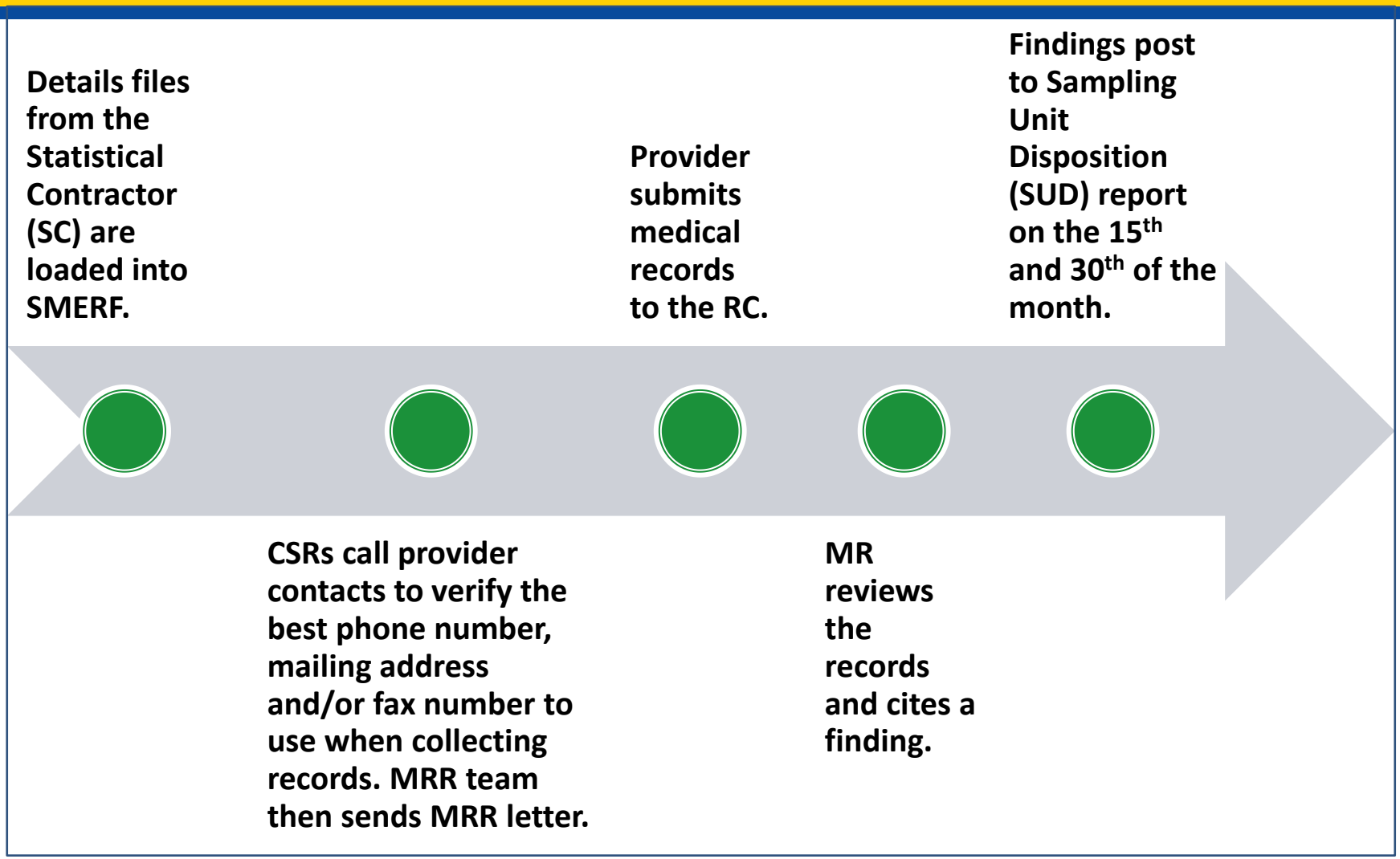
- A PERM MR is a comprehensive review performed by a PERM RC medical reviewer on sampled Fee-for-Service (FFS) claims.
- The PERM RC medical reviewer will evaluate each claim based on the medical record documentation, federal and state guidelines, and policies related to the claim.
- The objective of the review is to determine whether the service was medically necessary, provided in the appropriate setting, billed correctly, coded accurately, and paid correctly in accordance with federal and state policy.

Introduction to MR

Introduction to MR

- The RC's Customer Service Representative (CSR) team, MRR team, and MR team work closely together to ensure the MR team has all the records needed to complete MRs.

Introduction to MR, continued



MRR Process Overview

MRR Process

- The RC will notify the state about a week before the RC expects the details files based on the SC's estimated delivery schedule.
- The RC begins calls to either the billing provider or the medical records contact (if provided) upon receipt of the details files from the PERM SC.
- The RC will use the billing provider information, or the medical records contact information, if provided, to contact providers and send request letters.
  - A medical records contact is the entity responsible for the retention of the medical records for the sampled service if different from the billing provider. The state provides the medical records contact in the details files.
  - If the CSR cannot reach a provider, RC Regional Coordinators will contact the state to identify an alternate point of contact responsible for holding records.

MRR Process, continued

- CSRs will send the *Initial Request for Records* letter, and all follow up letters for the sampled claim(s) to the established records contact for the provider.
- In the State Medicaid Error Rate Findings (SMERF) system, under the PERM ID and under the Medical Records Requests section, the records contact name, phone number, and call log for each claim is available to state PERM representatives.
- *Initial Request for Records* packets sent to providers include four parts:
  - Records Request Letter (noting authority to request records).
  - Instructions for providers regarding submitting records.
  - Request for Records Cover Sheet with a specific list of requested documentation (unique to each claim category).
  - Claim Summary which provides detailed claims data for the specific sampled claim.

MRR/MR Process Flow Diagram

MRR Letter Sequence

- CSRs call provider contacts to verify the best phone number, mailing address and/or fax number to use when collecting records. MRR team then sends MRR letter.
- MRR team sends initial letter packet.
- CSRs send reminder letters and make follow up calls if documents not received.
- If partial documentation is received, MRR team sends Additional Documentation Requests (ADRs) at the below intervals:
  - Initial ADR.
  - 7 calendar days – reminder.
  - 15 calendar days – No ADR Response.

Submission Received

- MRR team loads submission into system.
- MRR screens submission.
- MRR returns PERM ID to CSR for additional provider outreach, if needed.
- If submission passes intake review, records are made available in SMERF for MR.
- MR begins review.
- MR may need additional documentation to complete review.
  - CSR contacts provider and sends ADR.
- If all records received, MR completes the review and cites findings.

Review Findings

- MR finding is posted in SMERF.
- State receives Advance Notice of Error PERM alert.
- Findings appear on SUD reports generated on 15th and 30th of each month.
- DR window starts when finding appears on SUD report.
  - For missing documentation errors (discussed later) the RC will accept documentation through the end of the cycle without the need to file a DR

MRR Letters

MRR Process: Initial Request

- **Initial Request**: Providers have 75 calendar days from the date of the initial letter to submit medical records.
  - The RC will follow up with reminder calls and reminder letters at 30 calendar days, 45 calendar days, and 60 calendar days if the record has not been received.
  - The RC sends a non-response letter to providers via certified mail if the RC receives no reviewable documentation after 75 calendar days.
  - This non-response letter triggers the citing of a system generated MR1* No Reviewable Documentation Received Error.
  - The provider has until the end of the cycle to submit documentation for MR1 errors and MR2 Document(s) Absent from Record errors.
  - Copies of all letters sent to providers will be made available to state PERM representatives through their SFTP Kiteworks accounts each week on Fridays.

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

MRR Process: ADR

- **ADR**: The RC MR team assesses all documentation received in the initial response and initiates an ADR letter if documentation is missing. Providers have 15 calendar days from the date of the ADR letter to submit the missing documentation.
  - PERM RC CSRs call the providers and explain the specific documents needed prior to sending the ADR letter.
  - The RC makes a reminder call and sends an ADR follow up letter at 7 calendar days.
  - If not received by the ADR due date, the RC sends an ADR non-response letter to providers, 15 calendar days after the initial ADR.
  - The ADR non-response letter triggers the claim to be moved into a system generated MR2*.
  - The provider has until the end of the cycle to submit documentation for MR1 and MR2 errors.

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

MRR Process: Record Submission

- State representatives have the option to submit medical records via our SFTP Kiteworks, through fax, or mail.
  - State representatives should send documentation or questions related to medical records to PERMRC_Docs@empower.ai via Kiteworks.
- Providers have the option to submit records to the RC via fax, mail (paper or encrypted CD, DVD, or USB thumb drive), or CMS's Electronic Submission of Medical Documentation (esMD) platform as noted in provider submission instructions.
  - The RC includes instructions for submitting records in each MRR letter packet sent to providers.
  - States and providers should **never** submit Protected Health Information (PHI), Personally Identifiable Information (PII), or medical record documentation to the RC via email, even if encrypted. The RC cannot accept emailed records except from the state via Kiteworks.

MRR Process: Record Submission, continued

- Medical records technicians process records received from providers and state PERM representatives into the RC Records Management System for reviewers to access to complete reviews.
- The RC will populate the Received Date on the Medical Records Request tab in SMERF within 3 to 5 business days after records receipt following intake quality control.

MRR Process: Initial MRR Letter Packet

- Initial MRR letter packet includes the following elements:
  1. PERM records request letter.
  2. Provider instructions for records submission.
  3. Request for Records Cover Sheet with document request list.
  4. Claim Summary.
- The following slides discuss the four parts of the initial MRR letter packet in detail.

Initial Letter Packet – Part 1
First Half of PERM Letter

- Section 1 in the red box on the next slide reflects the RC's return address.
- Section 2 shows the address block containing the provider's name, point of contact or department (attention line), and address which has been verbally verified by the RC.
- Section 3 reflects the date the request letter is generated, the PERM ID, and the billing provider's NPI.
  - Please remind providers to check this date if they receive a non-ADR PERM request letter via USPS mail **after** submitting documentation. It is possible the request letter was sent out prior to the RC's receipt of the submission.
- Section 4 displays the request letter sequence and purpose.
- Section 5 shows instructions in Spanish for calling the CSR department to request a Spanish-language letter.

Initial Letter Packet – Part 1 continued
First Half of PERM Letter

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Payment Error Rate Measurement Program
CMS PERM Review Contractor,
Empower AI
8701 Park Central Drive Suite 400-B
Richmond, VA 23227

1

ADDRESS BLOCK
Provider Name
Attn
Contact Address

2

Date: ***Date letter is sent***
Reference ID: *PERM ID*
OMB Control Number: 0938-0974
Billing Provider NPI: *10-digit NPI*

3

Request Type & Purpose: Initial Request for Records (First Request).
Subject: Records Request – This is an initial request for records.

4

To request a copy of this letter in Spanish, please contact the PERM Customer Service Department at 800-393-3068.

Para solicitar una copia de esta carta en Español, por favor de contactar al Departamento de Servicio al Cliente de PERM al 800-393-3068.

5

Dear Medicaid and/or CHIP Provider:

Initial Letter Packet – Part 1 continued
Second Half of PERM Letter

- Section 1 in the red box on the next slide conveys information about PERM, the CMS PERM website, and the reason for claim selection.
- Section 2 outlines provider response expectations, PERM's exemption from HIPAA authorization requirements, and that no reimbursement is authorized for the cost of records reproduction or mailing related to this audit.
- Section 3 shows the due date for the provider's response to the request for records and describes potential consequences related to failure to respond.
- Section 4 displays State representative and RC contact information (Provider Inquiries inbox and customer service line).
- Section 5 advises that reminder letters and additional documentation requests will be sent, as needed.
- The CFRs referenced within the letter are cited at the bottom left of the page.

Initial Letter Packet – Part 1 continued (2)
Second Half of PERM Letter

Dear Medicaid and/or CHIP Provider:

The Centers for Medicare & Medicaid Services (CMS), in partnership with the states, is measuring improper payments in Medicaid/CHIP under the Payment Error Rate Measurement (PERM)[1]program.Additional information about the PERM program is addressed on the CMS PERM website (www.cms.gov/PERM). Refer to the "Providers" link on the website.

Reason for Selection: A claim submitted by or on behalf of you/your organization has been randomly selected for review under this program. The review will be completed by CMS' Review Contractor (RC), Empower AI. 1

Action: Send a Copy of Original Documentation: Federal regulations require that you provide the medical record documentation to support claims for Medicaid/CHIP services upon request[2]. The following pages provide details of the claim or service(s) selected for review, the requested supporting documentation, and submission instructions.Please submit documentation as soon as possible, but no later than the due date provided below which is 75 days after the date of this initial request letter.A written response is required by the due date even if you are unable to locate the requested documents. Providing medical records for Medicaid / CHIP beneficiaries does not violate the Health Insurance Portability and Accountability Act(HIPAA). **Patient authorization is NOT required for the release of the requested documentation.** CMS and its contractors will remain in compliance with the Privacy Act and regulations. No reimbursement can be made for the cost of record reproduction or mailing. 2

When: ***Due Date***
Please provide the requested documentation by ***Due Date.*** **A response is still required by** ***Due Date*** **even if you are unable to locate the requested information.**

Consequences: If you fail to deliver the requested documentation or contact us by ***Due Date***, your state agency may pursue recovery of payment for this claim from you. 3

Assistance: If you have questions, please contact our Customer Service Representatives at (800) 393-3068, Medical Records Manager Allison Keeley at PERMRC_ProviderInquiries@empower.ai, or your state PERM representative, ***State Rep Name*** at ***XXX-XXX-XXXX*** Or ***State Rep Email Address***. **Do NOT send records or patient information by email.** 4

Note: *Selected providers could be contacted by the RC (via phone calls) throughout the PERM Audit: Initial Documentation Request, Additional Documentation Request(ADR), and No Response requests at the 30th, 45th, 60th, and 75th day, and final contact for cited errors.* 5

[1] [2] 42 CFR §431.804; Social Security Act Section 2107(b)(1) [42 CFR §431.950 et seq]; 45 CFR parts 160 and 164
42 CFR §431.950 6

Initial Letter Packet – Part 2
Record Submission Instructions

- Section 1 in the red box on the next slide provides instructions for gathering and submitting records.
- Section 2 on the next slide contains detailed information for submitting records via fax, mail, and esMD. Please note that the RC's mailing address for record submissions has changed since the RY23 cycle.
- Section 3 on the next slide addresses the RC's inability to reimburse charges associated with fulfilling MRRs.

Initial Letter Packet – Part 2 continued
Record Submission Instructions

Payment Error Rate Measurement (PERM)
Instructions for Submitting Requested Records/Documentation

1

To comply with this request, providers should review the attached Claim Summary page that identifies the specific patient, date of service, and the service(s) selected for review. Gather the documents shown on the attached Cover Sheet which are generally those needed to support the billed service(s). Please be sure that documentation (Notes, Plan of Care, etc.) issued from electronic records are signed and dated (electronic signature acceptable if permitted by state regulations). Once the documents are gathered, please choose **ONE** of the following methods to submit the records/documentation to the PERM Review Contractor.

1. Fax

a) Place PERM Cover Sheet on top of each record submission.
b) If your facility has ***more than one*** PERM ID request, please fax each submission separately.
c) Please submit documentation for each PERM ID in as few fax transmissions as possible.
d) Fax documents to: **1-804-515-4220**

2

2. Mail

a) Place PERM Cover Sheet on top of each record submission.
b) All documents must be complete and legible.
c) Please do not staple or paper clip any pages together.
d) If you choose to send the documentation on USB Flash Drive, CD, or DVD, the file(s) must be ***encrypted.*** Please submit the password for the encrypted USB Flash Drive, CD, or DVD via email to PERMRC_Encryption@empower.ai and include the PERM ID in the subject line. **Please do not submit medical records or patient information to this email address as it is not a secure method of transmission. Please note that USB flash drives cannot be returned to providers.**
e) Mail requested documentation to:

CMS PERM Review Contractor, Empower AI
8701 Park Central Drive Suite 400-B
Richmond, VA 23227

3. Electronic Submission of Medical Documentation (esMD)

Providers with an established relationship with a Health Information Handler (HIH) are encouraged to have their HIH submit the requested medical documentation via the gateway to **Electronic Submission of Medical Documentation (esMD). If your facility does not have an established relationship with an HIH, esMD will not be an available submission method.** For more information, see http://www.cms.gov/esMD/. Please ensure that any documents submitted through esMD are routed to PERM Empower AI.

If you choose to submit medical records via CMS's esMD system, you must enter the Reference ID (PERM ID #) from the records request letter into the ESMD CASEID field. If you enter any other information in this field, the system will not be able to identify the record automatically which will result in additional processing time.

NOTE: We are not authorized to reimburse providers/suppliers for the cost of retrieving, copying, or mailing records. Therefore, we cannot accept invoices for service fees.

3

Initial Letter Packet – Part 3
Request for Records Cover Sheet

- Request for Records Cover Sheet includes:
  - Beneficiary identifiers.
  - Provider identifiers.
  - Date(s) of service.
  - Records due date.
  - A list of records typically needed based on claim category.

Initial Letter Packet – Part 3 continued
Request for Records Cover Sheet (top)

Payment Error Rate Measurement (PERM)

REQUEST FOR RECORDS COVER SHEET

PERM-ID: [||PermID||]

Date: [||MRReSubDate||]

Beneficiary Name: [||BeneficiaryName||]	**Billing Provider Number:** [||ProviderID||]
Date of Birth: [||BeneficiaryDOB||]	**Billing Provider Name:** [||ProviderName||]
BeneficiaryID: [||BeneficiaryID||]	
Claim Date(s) of Service: [||**DOSFrom**||] - [||**DOSTo**||]	
Sampled Date(s) of Service: [||**DOSFrom**||] - [||**DOSTo**||]	
Category 14: Laboratory, X-Ray, and Imaging Services	
Record Submission Due Date: [||**MedrecDueDate**||]	

Please place this page on top of the documentation submission.
Please provide the name and contact phone number of the individual submitting the documents in support of this request. This information may be used if additional information is necessary.

Name: _____ **Contact Phone Number:** _____

Initial Letter Packet – Part 3 continued
Request for Records Cover Sheet (bottom)

Laboratory, X-Ray, and Imaging Services

Please submit all documents applicable to the date(s) of service (DOS) noted to support the claim sampled. Some documents listed may not be necessary for all claims, **but please make every attempt to include the bolded items**. Please indicate which documents are being submitted. *If the list below is not applicable to your claim, please submit the documentation that supports the service(s) you billed as shown on the Claim Summary page.* **Please be aware that some documents required for review may be created before the claim DOS (e.g., orders or care plans) but are applicable to the sampled claim.**

- **Physician/Non-Physician Order/Requisition Form, if required (*signed and dated*)**
- **Reports/Results/Interpretations of Laboratory Services (*signed and dated)***
- **Reports/Results/Interpretations of Radiology/Imaging (*please do not send X-Ray films or copies*) (*signed and dated)***

Note: *Please submit the complete medical record with signatures as appropriate for the service(s) billed for the sampled claim. The documents listed above are frequently required for this category and service type. Please be sure to include these with your document submission, if applicable to the sampled claim.*

Initial Letter Packet – Claim Categories 1 through 4

Category	Type of Service
1	**Inpatient Hospital Services:** • Acute Inpatient. • Long-Term Acute. • Acute Inpatient Rehabilitation. • Opioid Treatment Program.
2	**Psychiatric, Mental Health, and Behavioral Health Services:** • In/Outpatient Psychological, Psychiatric, and Behavioral Health Services. • Drug and Alcohol In/Outpatient Services. • Group Homes. • Opioid Treatment Program.
3	**Nursing Facilities, Chronic Care Services, or Intermediate Care Facilities (ICF):** • Nursing Home and Convalescent Centers. • Chronic Care.
4	**Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes**

Initial Letter Packet – Claim Categories 5 through 9

Category	Type of Service
5	**Clinic Services:** • Hospital-based Clinics. • Federally Qualified Health Centers (FQHC). • Indian Health Services (IHS). • Rural Health Clinics (RHC). • Opioid Treatment Program.
6	**Physicians and Other Licensed Practitioners Services (Includes Advanced Practice Nurse, Physician Assistant, Nurse Midwife, and Midwife).**
7	**Dental and Oral Surgery Services.**
8	**Prescribed Drugs.**
9	**Home Health Services:** • Home Health Agency Services and Medical Supplies. • Equipment and Appliances through the Agency.

Initial Letter Packet – Claim Categories 10 through 13

Category	Type of Service
10	**Personal Support Services:** • Personal Care Services: ▪ Qualified Service Provider, Personal Care Attendant, Aide (certified nursing assistant), Homemaker Services, and Respite Care. • Case Management/Targeted Case Management Services. • Private Duty Nursing. • Meal Delivery Services.
11	**Hospice Services:** • Services Provided at Home, or in a Nursing Facility, Hospital, or Hospice Facility.
12	**Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology, Ophthalmology, Optometry, and Optical Services, and Rehabilitation Services, Necessary Supplies and Equipment.**
13	**Day Habilitation, Adult Day Care, Foster Care, or Waiver Programs and School-Based Services.**

Initial Letter Packet – Claim Categories 14 through 17

Category	Type of Service
14	**Laboratory, X-Ray, and Imaging Services.**
15	**Outpatient Hospital Services:** • Outpatient services (to include outpatient clinics not located within hospital complexes). • Emergency Services. • Rural Emergency Hospitals.
16	**Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications.**
17	**Transportation and Accommodations.**

Initial Letter Packet – Part 4
Claim Summary

- Claim Summary includes:
  - Beneficiary details.
  - Dates of service – both the claim span date and the sampled dates. These may or may not be the same.
    - A note discussing this is included beneath the **Sampled Date(s) of Service** line.
  - Diagnosis codes.
  - Procedure codes.
  - National Drug Code (NDC).
  - Prescription (Rx) number.
  - Diagnosis Related Group (DRG).
  - Amount paid.
  - PERM ID.
  - Due date for record submission.
- Claim summary information is populated into the highlighted fields from the data provided by the state in the details files.

Initial Letter Packet – Part 4 continued
Claim Summary

Payment Error Rate Measurement (PERM)

Claim Summary

Please refer to the Request for Records Cover Sheet, Request for Additional Documentation Cover Sheet, Request for Resubmission of Documentation Cover Sheet, or Request for Resubmission of Additional Documentation Cover Sheet for a list of documents to submit in support of the billed service(s) below.

Billing Provider Number:	*10-digit NPI*	**Request Date:**	*Date of letter*
Beneficiary/Patient Name:	*Bene name*	**PERM-ID:**	*PERM ID*
Beneficiary ID:	*Medicaid ID*	**Claim Category:**	*Claim category*
Date of Birth:	*DOB*	**State Claim ID:**	*ICN/TCN*
Claim Date(s) of Service:	*Claim DOS*	**DUE DATE:**	***Response Due Date***
Sampled Date(s) of Service:	*DOS for sampled lines*		

PERM may sample a single line of a claim or the whole claim; both DOS are shown for your reference.

Diagnosis Code	Procedure Code	NDC Code	RX Number	DRG	Amount Paid
DX code(s)	*Procedure code(s), if applicable*	*NDC code(s), if applicable*	*RX number(s), if applicable*	*DRG, if applicable*	*Dollar amount paid*

Generation of an ADR Request

- A medical reviewer evaluates the medical documentation received in response to the initial request.
- If the documentation available does not support the services being billed based on the federal and/or state policy, the reviewer will request additional documentation from the provider through the ADR process.
- The provider/state will have 14 calendar days to submit the requested additional documentation.
- If additional documentation is received, the medical reviewer will evaluate the documentation and make a determination on the claim.

MRR Process: ADR MRR Letter Packet

- ADR MRR letter packet includes the following:
  1. PERM ADR records request letter.
  2. Provider instructions for records submission.
  3. Request for Additional Documentation Cover Sheet listing missing documentation and relevant policy citations supporting the need for the outstanding document(s).
  4. Claim Summary.
- The following slides discuss the PERM ADR records request letter (part 1) and the Request for Additional Documentation Cover Sheet (part 3) in detail, noting that parts 2 and 4 are the same format as the Initial request letter sequence.

ADR Letter Packet – Part 1
PERM ADR Letter

- The PERM ADR Records Request Letter includes:
  - The same information at the very top as the Initial PERM letter: return address, provider name and address, request date, PERM ID, and provider NPI (not shown on the next slide).
  - Section 1: The request letter sequence.
  - Section 2: instructions in Spanish for calling the CSR department to request a Spanish-language letter.
  - Section 3: Information about PERM, the CMS PERM website, and the reason for claim selection.
  - Section 4: Note thanking the provider for their initial response, advisement that documentation is still outstanding, provider response expectations and timeline, PERM's exemption from HIPAA authorization requirements, and notification that no reimbursement is authorized for the cost of records reproduction or mailing related to this audit.

ADR Letter Packet – Part 1 continued
PERM ADR Letter

- The PERM ADR Records Request Letter includes:
  - Section 5: Due date for response to the additional documentation request for records and consequences related to failure to respond.
  - Section 6: State representative and RC contact information (Provider Inquiries inbox and customer service line).
  - Section 7: advisement that reminder letters and additional documentation requests will be sent, as needed.
  - Section 8: The CFRs referenced within the letter are cited at the bottom left of the page.

ADR Letter Packet – Part 1 continued (2)
PERM ADR Letter

Request Type & Purpose: Additional Documentation Request (First Additional Documentation Request)
Subject: Additional Documentation – This is not a duplicate request. 1

To request a copy of this letter in Spanish, please contact the PERM Customer Service Department at 800-393-3068.

Para solicitar una copia de esta carta en Español, por favor de contactar al Departamento de Servicio al Cliente de PERM al 800-393-3068. 2

Dear Medicaid and/or CHIP Provider:

The Centers for Medicare & Medicaid Services (CMS), in partnership with the states, is measuring improper payments in Medicaid/CHIP under the Payment Error Rate Measurement (PERM)[1] program.

Reason for Selection: A claim submitted by or on behalf of you/your organization has been randomly selected for review under this program. The review will be completed by CMS' Review Contractor (RC), Empower AI. 3

Action: Send Additional Documentation: A request for the medical/supporting record was sent to you on *Date of initial letter* for the beneficiary listed on the enclosed Claim Summary. Thank you for your response to the request. It has been determined by the reviewer, however, that additional documentation is needed to complete the review of this claim. The following pages provide details of the claim or service(s) selected for review, the requested supporting documentation, and submission instructions. **Your cooperation in submitting the additional documentation to us within fourteen (14) days is essential to ensure that the claim is accurately reviewed to determine proper payment.** Federal regulations require that you provide the medical record documentation to support claims for Medicaid/CHIP services upon request[2]. **Providing medical records for Medicaid/CHIP beneficiaries does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization *IS NOT REQUIRED* to provide medical records in response to this request.** CMS and its contractors will remain in compliance with the Privacy Act and regulations. 4

When: ***ADR Due Date***
Please provide the requested documentation by ***ADR Due Date.*** **A response is still required by *ADR Due Date* even if you are unable to locate the requested information.**

Consequences: If you fail to deliver the requested additional documentation or contact us by ***ADR Due Date***, the claim will be cited as an erroneous payment and your state agency may pursue recovery of payment for this claim from you. 5

Assistance: If you have questions, please contact our Customer Service Representatives at (800) 393-3068, Medical Records Manager Allison Keeley at PERMRC_ProviderInquiries@empower.ai, or your state PERM representative, *State Rep Name* at XXX-XXX-XXXX Or *State Rep Email Address*. **Do NOT send records or patient information by email.** 6

Note: Selected providers could be contacted by the RC (via phone calls) throughout the PERM Audit: Initial Documentation Request, Additional Documentation Request(ADR), and No Response requests at the 30th, 45th, 60th, and 75th day, and final contact for cited errors. 7

[1] [2] 42 CFR §431.804; Social Security Act Section 2107(b)(1) [42 CFR §431.950 et seq]; 45 CFR parts 160 and 164
42 CFR §431.950 8

ADR Letter Packet – Parts 2 and 4
Record Submission Instructions and Claim Summary

- Part 2 – Provider Instructions for Submission – has been skipped/is not covered again under the ADR request as part 2 is identical for both the initial and ADR requests.
  - *Part 2 can be accessed here: Record Submission Instructions.*

- Part 4 – Claim Summary – has been skipped/is not covered again under the ADR request as this part is formatted the same for both the initial and ADR requests.
  - *Part 4 can be accessed here: Claim Summary.*

ADR Letter Packet – Part 3
Request for Additional Documentation Cover Sheet

- The Request for Additional Documentation Cover Sheet specifies the additional documentation requested and includes:
  - Beneficiary identifiers.
  - Provider identifiers.
  - Dates of service.
  - Due date for record submission.
  - A list of the additional records needed and the relevant policy citation requiring those records.
- Unlike the request for records cover sheet in an initial records request, the ADR Cover Sheet only lists the additional records needed.

ADR Letter Packet – Part 3 continued
Request for Additional Documentation Cover Sheet

Payment Error Rate Measurement (PERM)

REQUEST FOR ADDITIONAL DOCUMENTATION COVER SHEET

PERM-ID: *PERM ID*

Date: *Date of letter*

Beneficiary Name: *Beneficiary name* **Date of Birth:** *DOB* **Beneficiary ID:** *Beneficiary Medicaid ID* **Claim Date(s) of Service:** *DOS* **Provider Name:** *Provider name* **Category X:** *Claim category description*	*Claim-specific QR code will populate here*
Record Submission Due Date: *ADR Due Date*	**Review ID:** *6-digit Review ID*

The following **additional** documentation is needed.

Requested Document(s) type and description:

- *NAME OF MISSING DOCUMENT* **(signed and dated; relevant to sampled claim)** - Additional Documentation is required to support *specific billed code(s), units, and code description*, for sampled dates of service xx/xx/xxxx - xx/xx/xxxx.

  Please submit the *name of missing document. Additional information regarding document dates or issues with prior submission will be entered here, if required.*

  Policy citation requiring the documentation requested will populate here.

Please help ensure accurate processing by placing this page on top of the records you are submitting.

Communication of MRR Progress

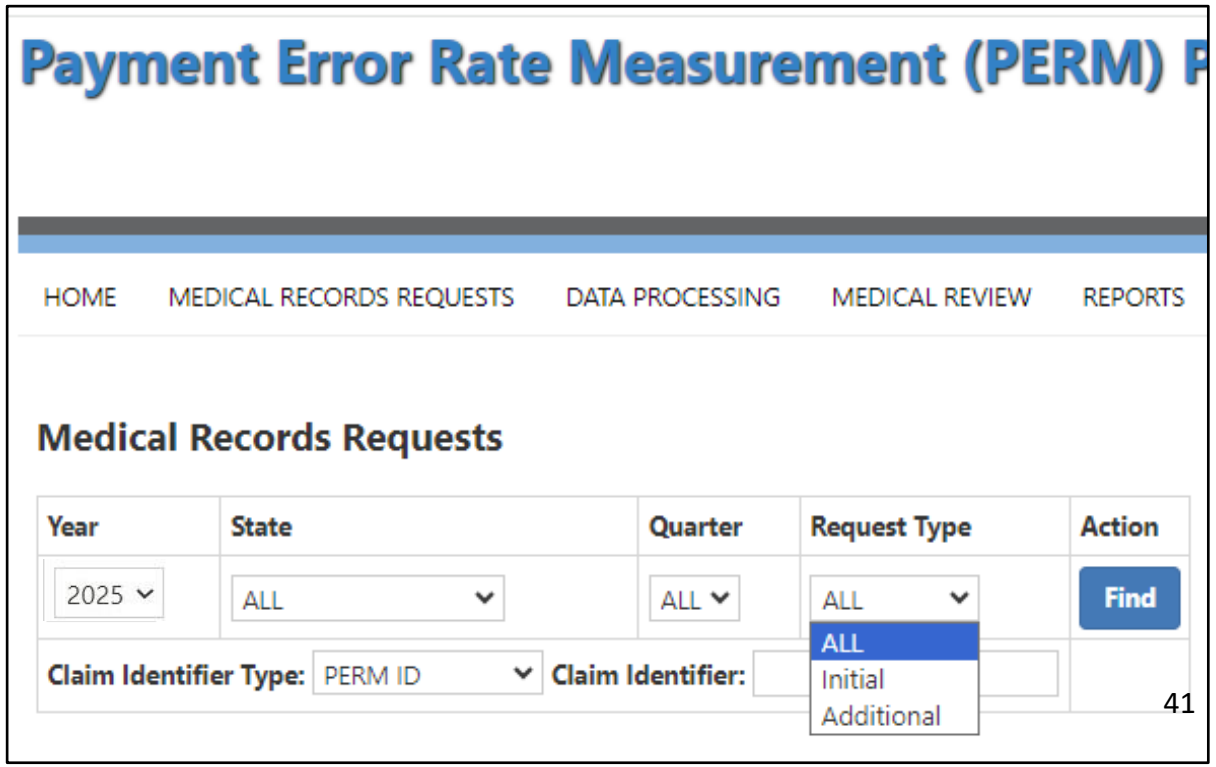
- The PERM RC will provide MRR updates to states during regular check-in calls.
- MRR discussion points will include:
  - Volume and status of recent initial requests.
  - Volume and status of recent ADR requests.
  - Reports and discussions related to MR1* errors, MR2* errors, and provider follow up by CSR team and/or state PERM representatives.
  - If state support has been requested to secure any new point(s) of contact for records requests, progress of such requests is discussed.

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

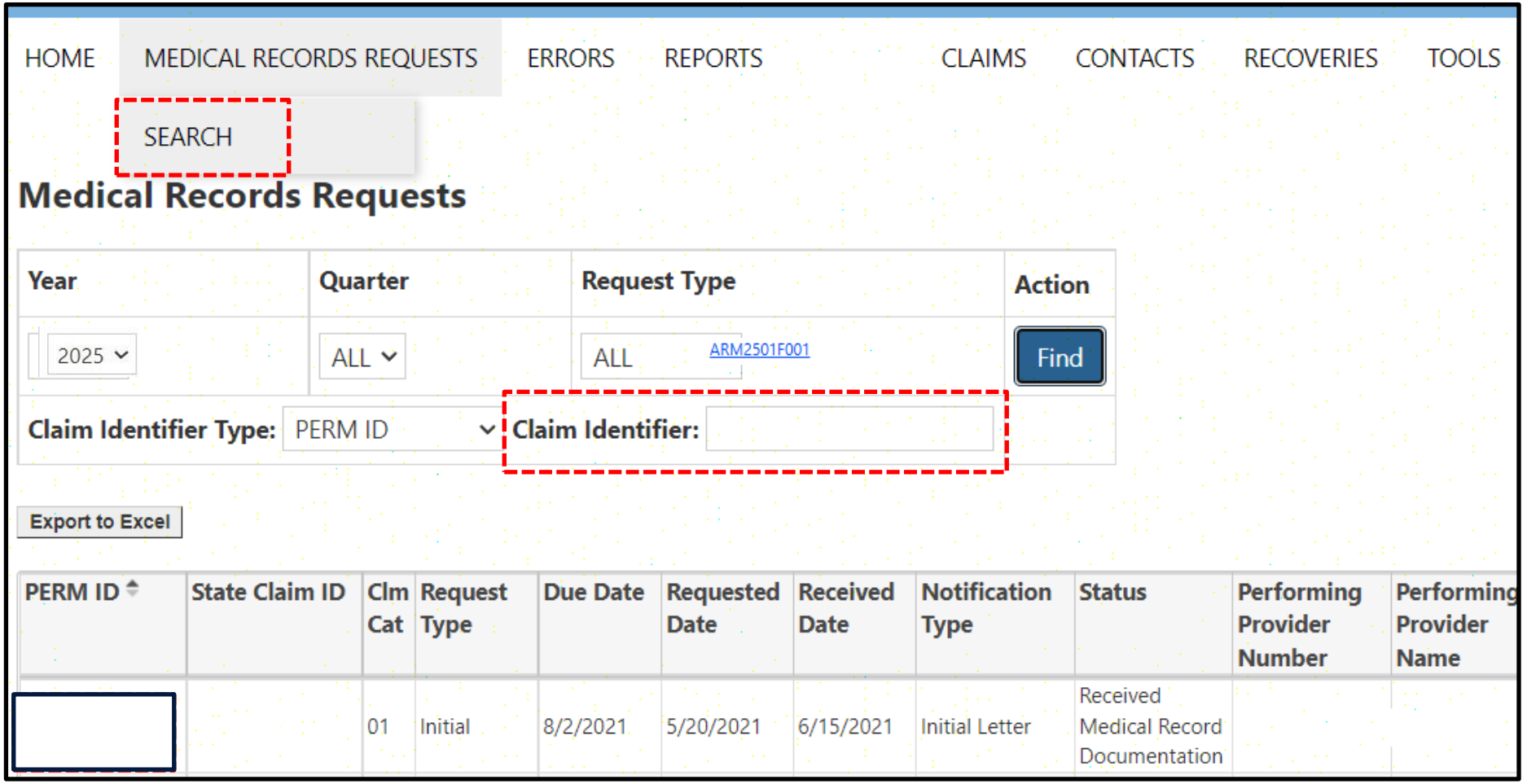
SMERF Resources for MRR

MRR - MRR Queries

- Users may identify the most recent medical records request status for your state's sampled claims. This will indicate the most recent letter sequence which was sent out or will indicate if documentation has been received in response to a request by using the Medical Records Request search feature.
- The search can be narrowed by reporting year, quarter, request type, and claim identifier.

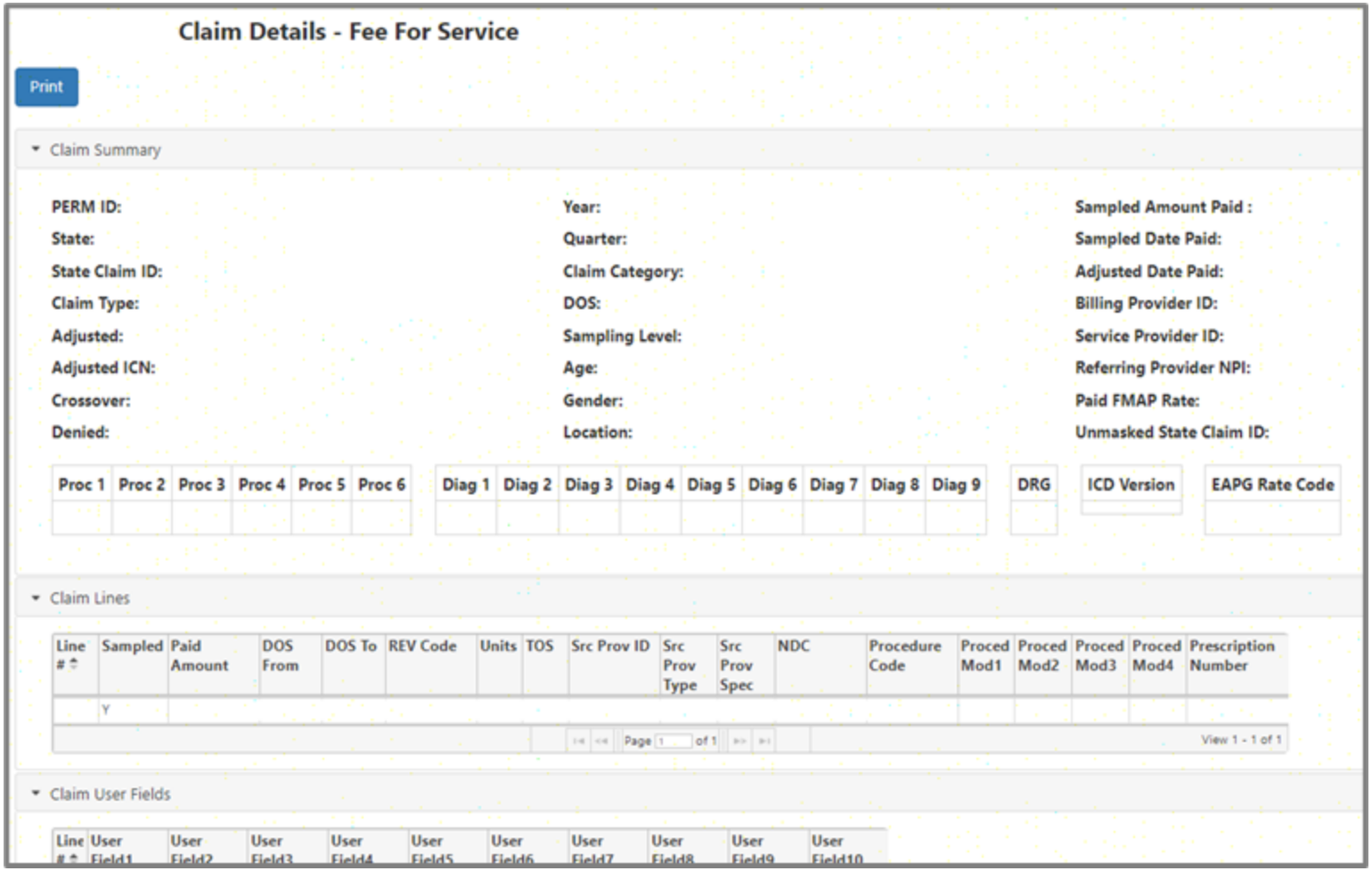


MRR Query Results



- Clicking on the PERM ID link will route users to the SMERF Claim Details page.

MRR Query Results, continued

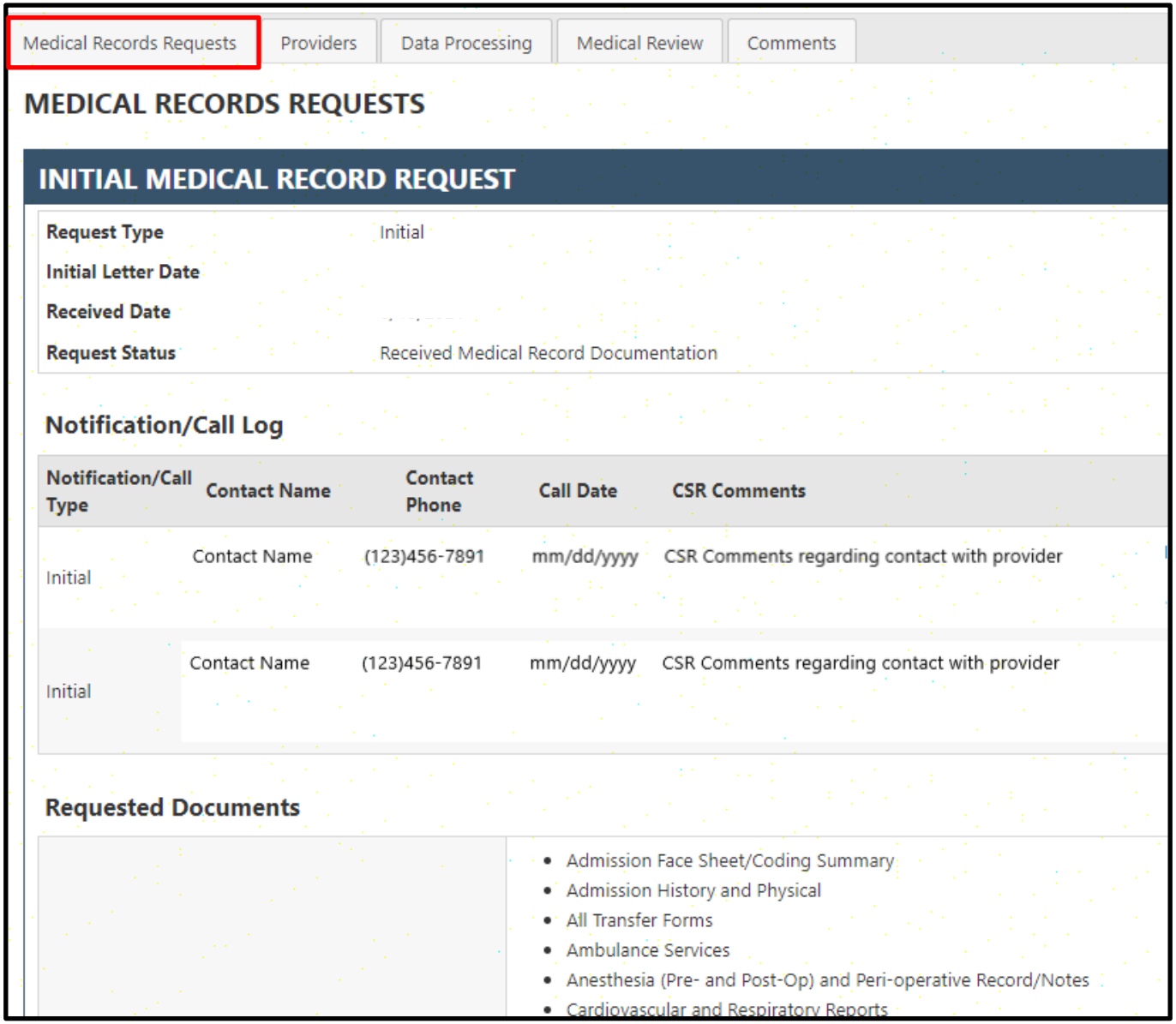


- Image above shows details after clicking on the PERM ID shown in the previous slide.

MRR - MRR Query Results

- Detailed information on requests for records can be found on the Medical Records Requests tab and includes the following:
  - Date the MRR letter was sent.
  - Call logs detailing outreach made to the provider.
  - Documents requested to complete the MR.
- The next slide shows the above information displayed in SMERF.

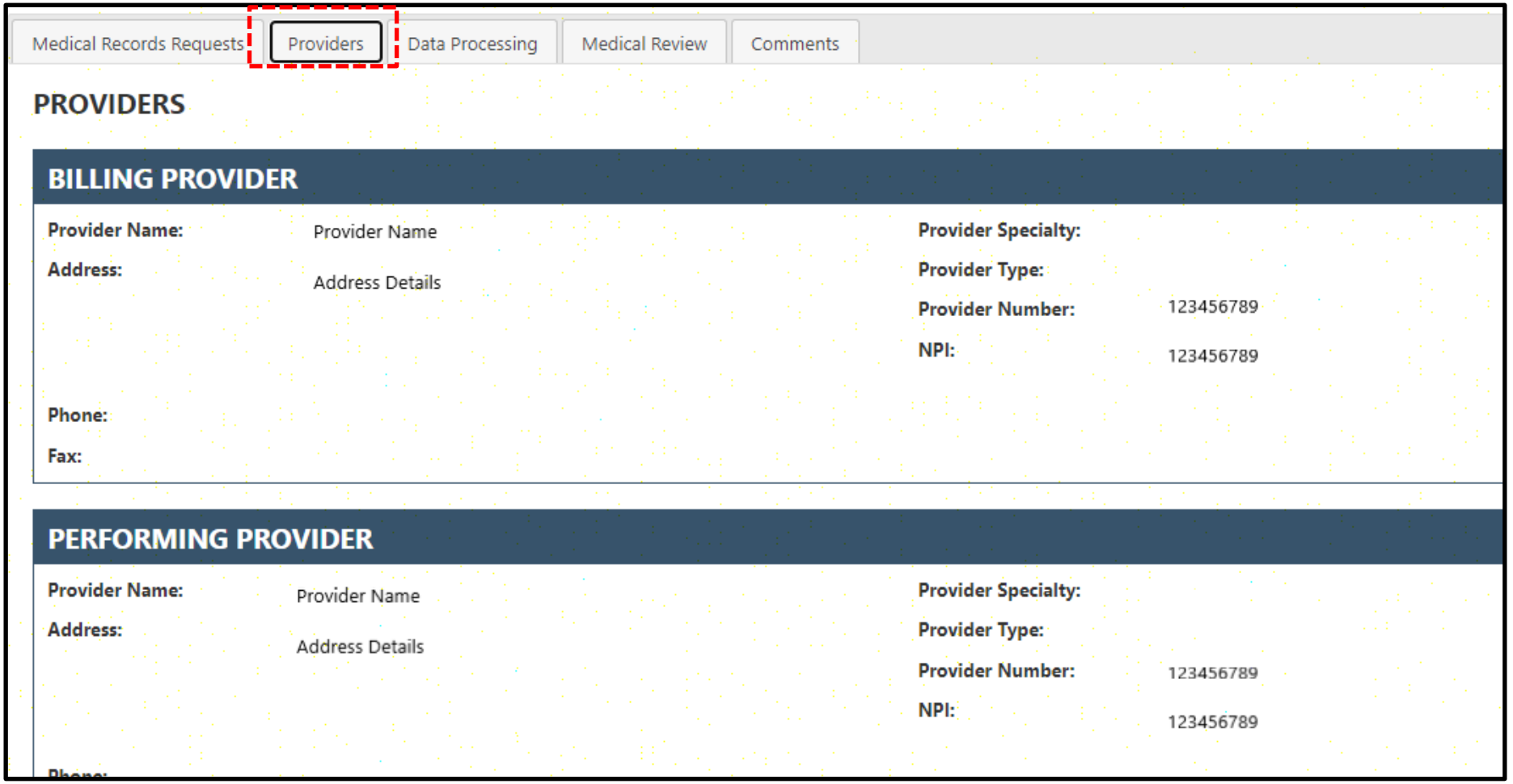
MRR - MRR Query Results, continued



MRR - MRR Query Result Detail - Providers Tab

- The Providers tab includes the following information:
  - Address.
  - Phone number.
  - Fax number.
  - Billing provider specialty.
  - Billing provider type.
  - Billing provider National Provider Identifier (NPI) information on the billing provider.
  - Performing provider if applicable.
  - Referring provider if applicable.
- See next slide for an image of the Providers tab.

MRR - MRR Query Result Detail - Providers Tab, continued



MR Process Overview

Basic Steps in MR Process

Master Policy List (MPL)

MPL finalized with state and policies loaded into SMERF.

Records Received

Review of records to determine if complete and legible.

ADR will be sent if additional records are needed for review.

Cite Finding

Determine payment accuracy and cite finding in SMERF.

Findings post to SUD on 15th and 30th.

MR Process – Policy Collection

- The RC compiles state policies and regulations to create a state-specific MPL and works with each individual state to create a final MPL each cycle by following these steps:
  - The RC obtains publicly available state and federal regulations and policy information through individual research.
  - The RC gathers information from state responses provided in the State Information Survey and the MRR MR Policy Questionnaire.
  - Using information obtained in the above steps, the RC creates a draft MPL and sends the draft to each state for review and confirmation that the MPL is complete and accurate.
  - Once the state approves the MPL, the RC uploads the policies and regulations into SMERF for reference while completing the MR portion of the PERM audit.

MR Process

- The RC will complete MR on each sampling unit within 20 calendar days after receipt of the complete medical record for the associated sampling unit.
- The RC will complete a review on all sampling units to ensure the sampling unit was properly paid, reduced, or denied, which may require a cross check between the data processing and MR functions.
- In most cases PERM will only sample individual line items; however, it may be necessary for the RC to review all items on a claim to determine the accuracy of the individual line sampled.
- The RC will only cite errors for the individual line sampled by the SC.

MR Process, continued

- An MR error is an error resulting in an overpayment or underpayment that is determined from a review of:
  - Provider's medical record or other documentation supporting the service(s) claimed.
  - Federal regulations that are applicable to conditions of payment.
  - States' written policies.
  - Comparison between the documentation, federal regulations, written policies, and the information presented on the claim.

MR Steps and Considerations

Medical Review Steps	Considerations
The RC medical reviewer (nurse and certified coder) will determine whether the RC received sufficient documentation for MR. **Note:** If sufficient documentation is not submitted, additional documentation must be requested prior to citing all MR2, MR4, MR5, MR7, MR8, and MR10* error findings. *Click the link to view the slide with MR error code definitions.	Did the RC receive all requested information? The original MRR lists the specific supporting documents providers are asked to submit for each claim category.
Determine whether the service was provided in accordance with federal and state policy.	Is the procedure documented in the medical record a covered service under state and federal policies? Are there any service limitations applicable to the covered service (e.g., units, quantities)? Were the services provided within those limitations?
Confirm the medical necessity of the service.	Were the services provided consistent with the symptoms or diagnosis under treatment? Does the documentation support the patient's condition and the provider's treatment of the patient's condition?

MR Steps and Considerations, continued

Medical Review Steps	Considerations
Determine whether the service provided matches the service codes the provider billed and the payer paid.	Are the procedures and corresponding diagnoses relevant to the billed procedure code? Did the provider bill the correct code for the service?
Verify appropriate physician certification.	If required by state policy, is there a signed physician certification for long-term care, inpatient hospital services, and/or home health?
Enter claim review determination.	Is the payment correct? Is there an error? Reviewers record results in SMERF.

Preliminary MR Finding Codes

Code	Definition	Code	Definition
C1*	Correctly Paid	MR6	Number of Unit(s) Error
MR1	No Reviewable Documentation Received Error	MR7	Medically Unnecessary Service Error
MR2	Document(s) Absent from Record Error	MR8	Policy Violation Error
MR3	Procedure Coding Error	MR9	Improperly Completed Documentation
MR4	Diagnosis Coding Error	MR10	Administrative/Other Error
MR5	Unbundling Error		

Note:

* **A finding of C1** means that the medical reviewer found no payment error in the claim, i.e., the review resulted in a correct finding.

Repricing of MRs

- When repricing a sampling unit, the RC will first determine the total value of the sampling unit.
- If the sampling unit was in error, the RC will determine the initial dollar value as 100% of the paid amount.
- States may utilize the DR process for repricing or request repricing via email to the RC after the DR timeframe closes until the end of the cycle.
  - The state must provide supporting documentation verifying the accuracy of the repricing, such as rate schedules or screen shots.
  - If the documentation is not sufficient to support the repriced amount, the initial dollar value will remain in place.
- The most common codes for repricing include MR3, MR4, MR5, MR6, MR7, MR10*.

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

SMERF Resources for MR

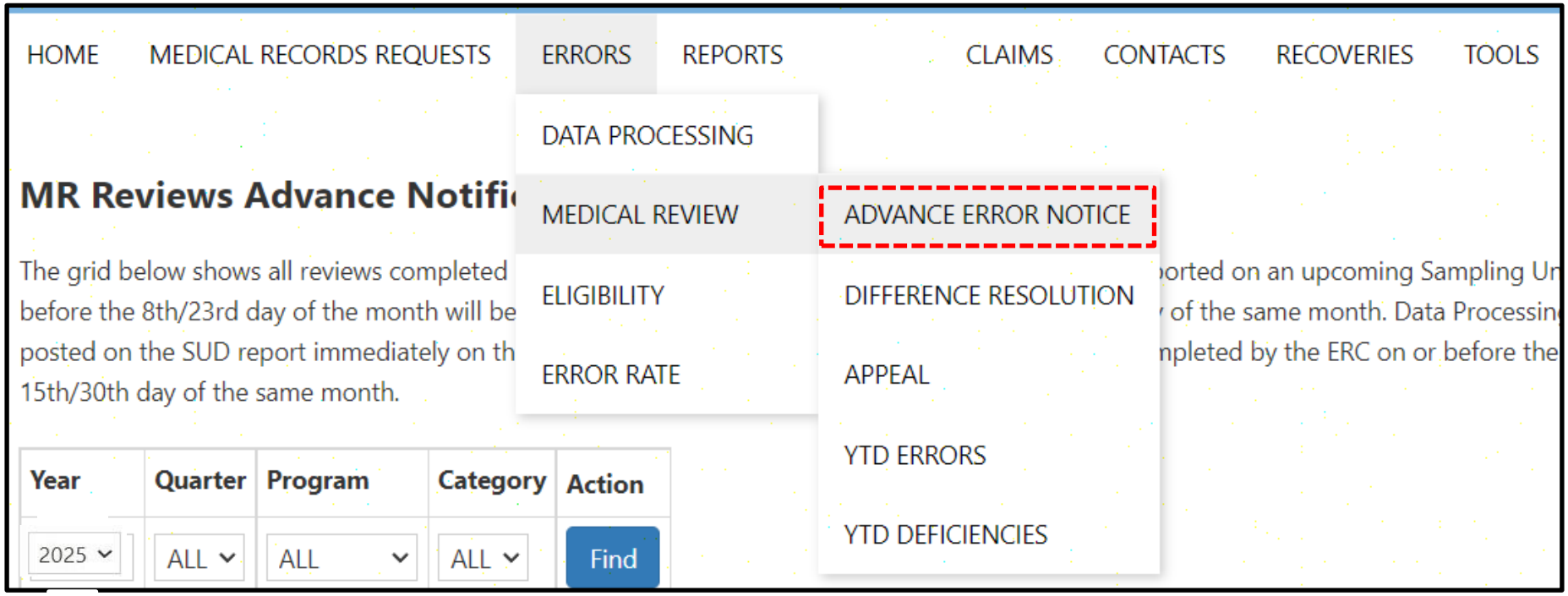
Errors - MR Advance Error Notice

- Check all the reviews completed by the RC or Eligibility Review Contractor (ERC) that have an error finding and will be reported on an upcoming SUD Report by choosing 'Advance Error Notice' under the Errors/Review Type menu.
- In the image on the next slide, the user has selected Errors then Medical Review to see menu options for the MR review type. (Note: Findings do not post to the Advance Error Notice immediately but will be available for review within 24 hours).
- The RC sends each state copies of medical records associated with all MR2-MR10* errors via Kiteworks.
- The RC provides medical records to the state in advance of the SUD report.

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

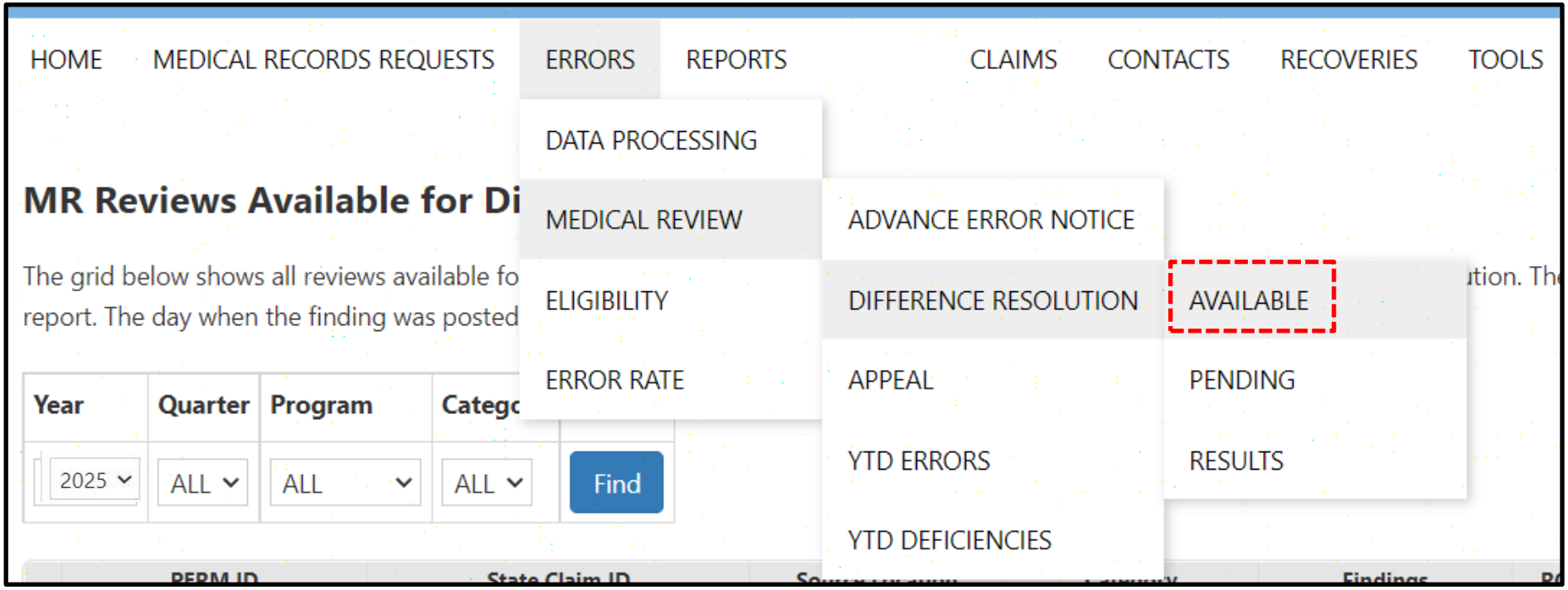
Errors - MR Advance Error Notice, continued

- Review MR errors that have been cited but not yet posted to the SUD report by choosing Advance Error Notice under the Errors/Medical Review menu.



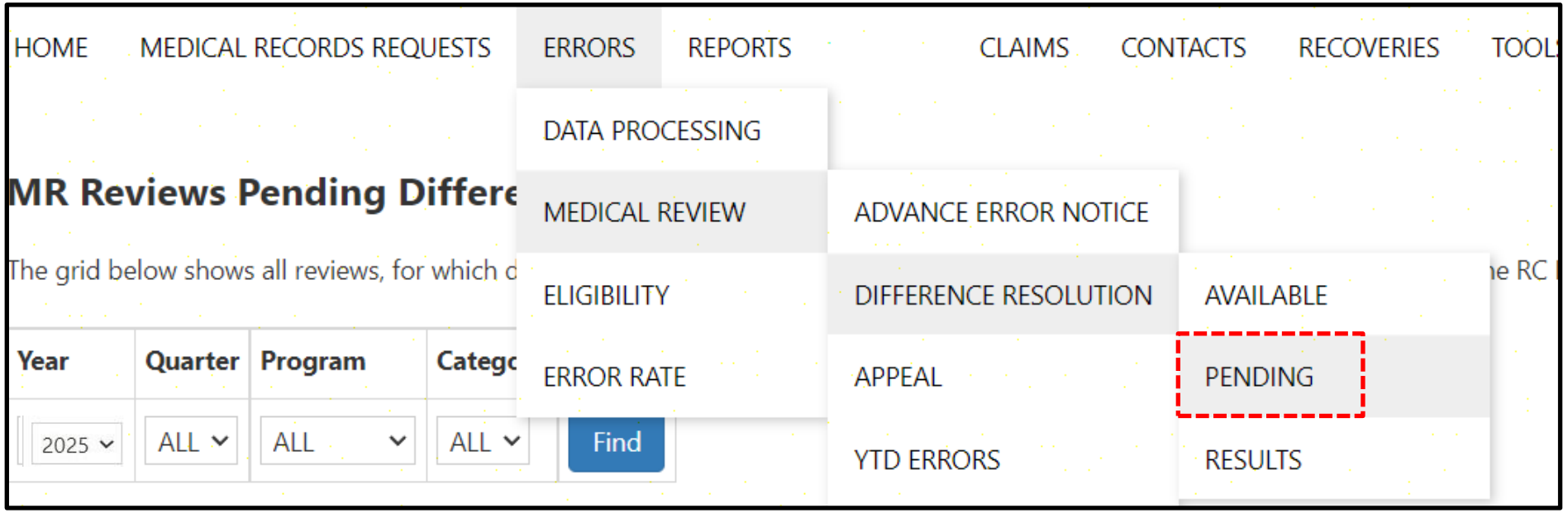
Errors - MR DR Available

- Review MR errors eligible for DR by choosing Available under the Errors/Medical Review/Difference Resolution menu.



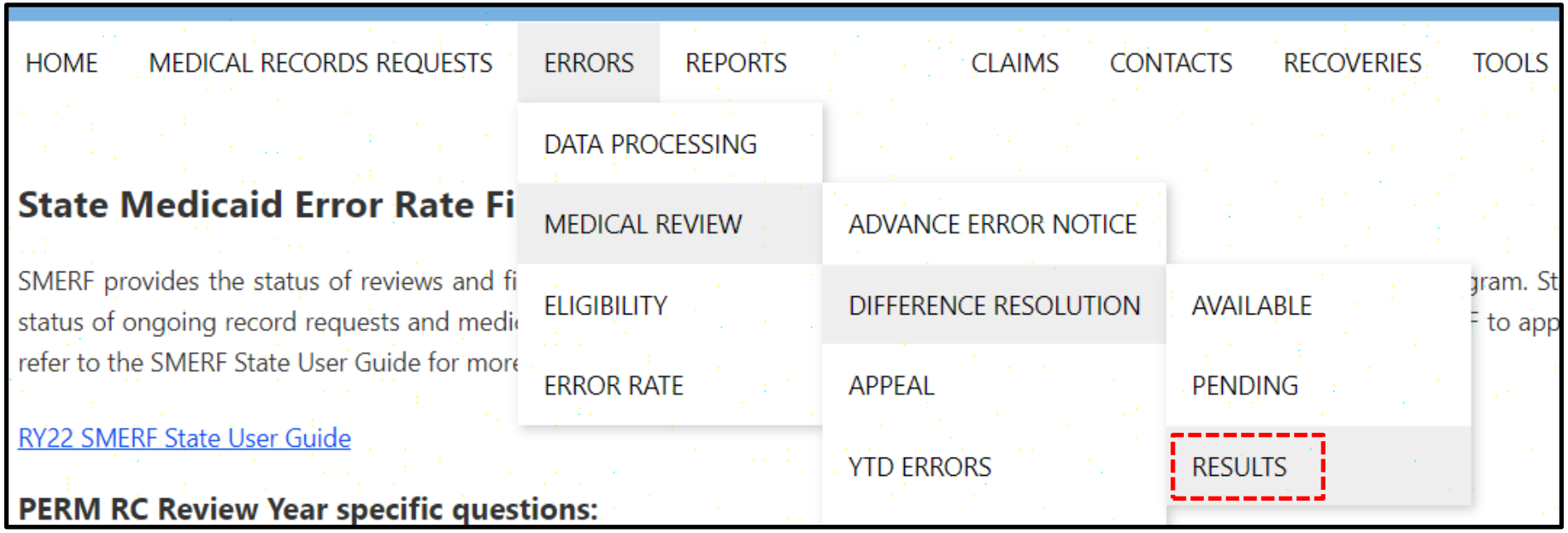
Errors - MR DR Pending

- Review MR pending DR by choosing Pending under the Errors/Medical Review/Difference Resolution menu.



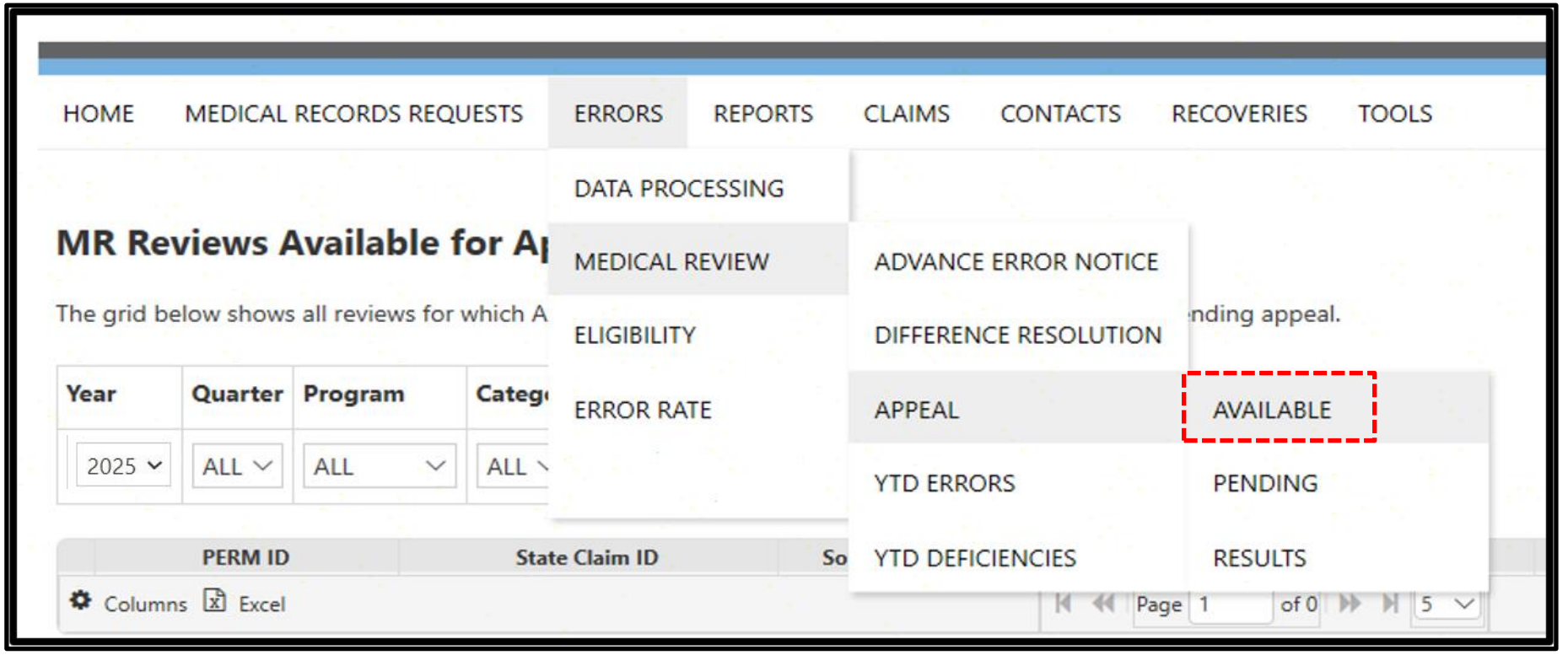
Errors - MR DR Results

- Review completed DR findings by choosing Results from the Errors/Medical Review/Difference Resolution menu.



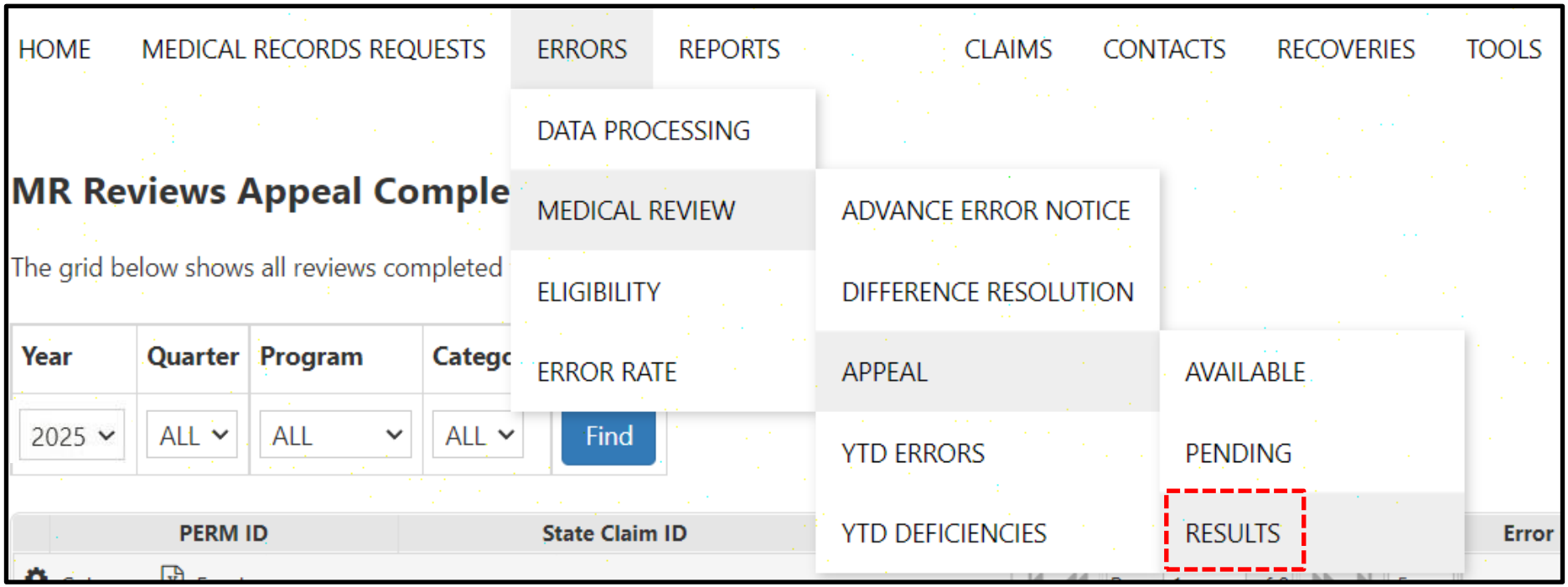
Errors - MR Appeals Available

- Review MR DRs eligible for Appeal by choosing Available under the Errors/Medical Review/Appeal menu.



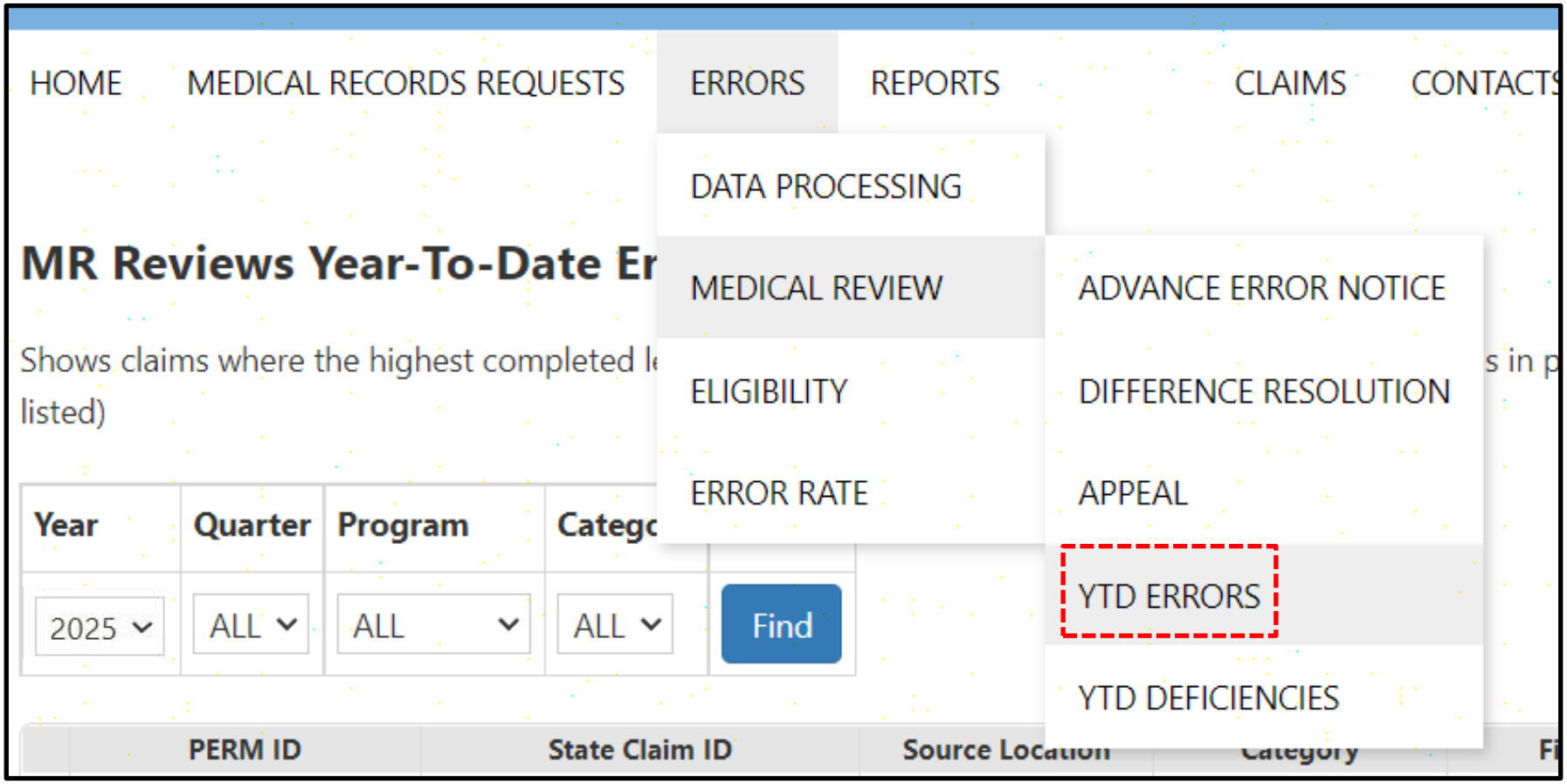
Errors - MR Appeals Results

- Review completed MR appeals by choosing Results under the Errors/Medical Review/Appeal menu.



Errors - MR YTD Errors

- To review YTD MR errors, choose YTD Errors under the Errors/Medical Review menu.

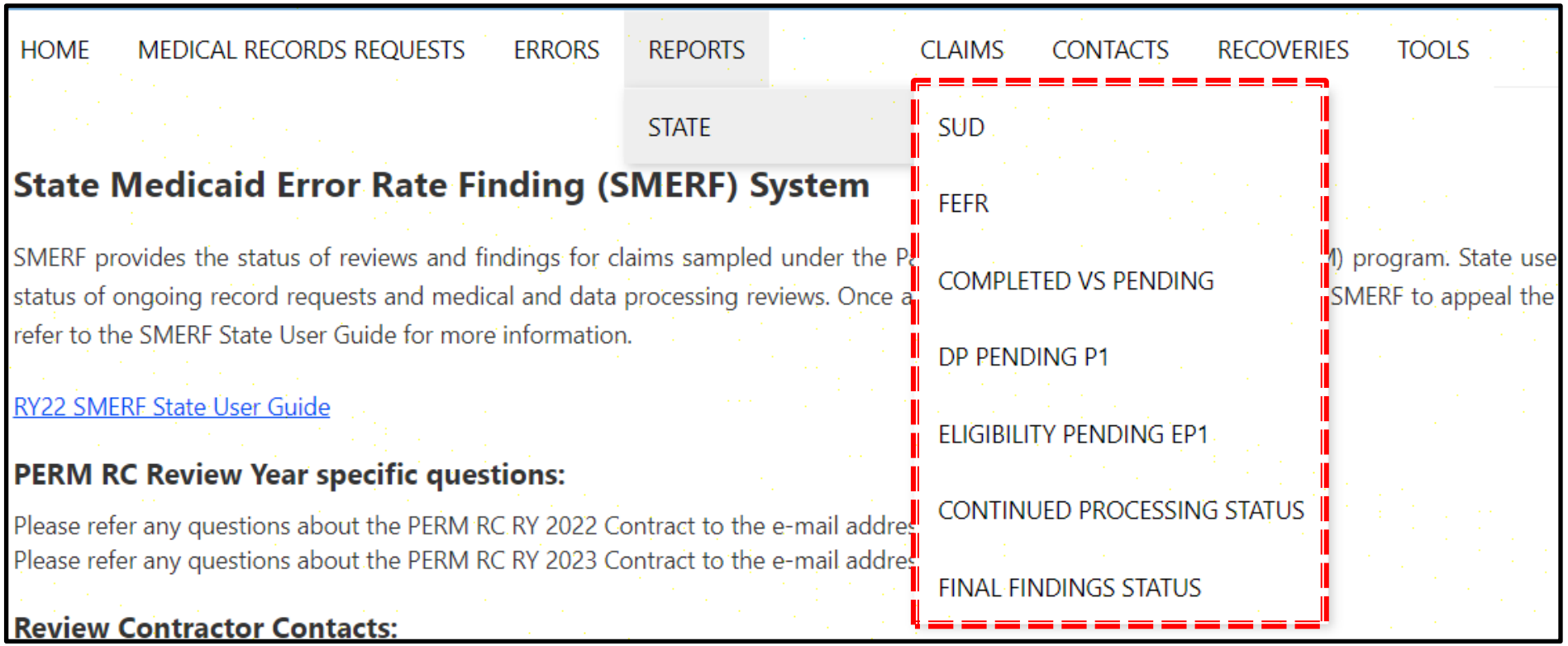


Reports in SMERF

- Numerous reports are available to state users in SMERF.
- Most SMERF reports can be exported in Excel, Word, or PDF file types by clicking the “Save” icon.
- Users can also click “Export to Excel” to export many reports.
- Choosing “Export to Excel” allows you to select the columns to export to Excel.
- See the next slide for an image of the reports available in SMERF.

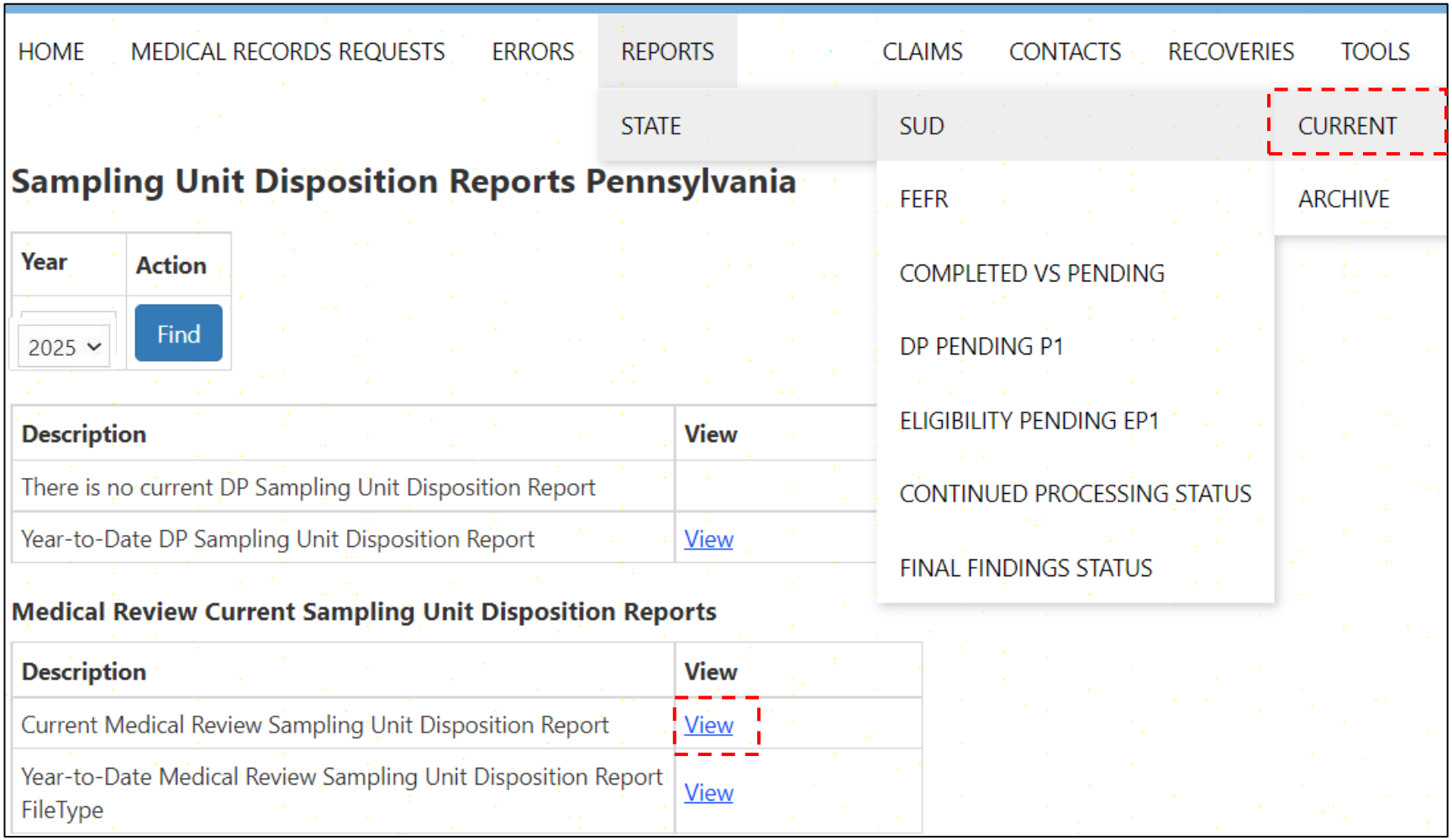
Reports in SMERF, continued

- To view reports available in SMERF, click on State under the Reports menu.



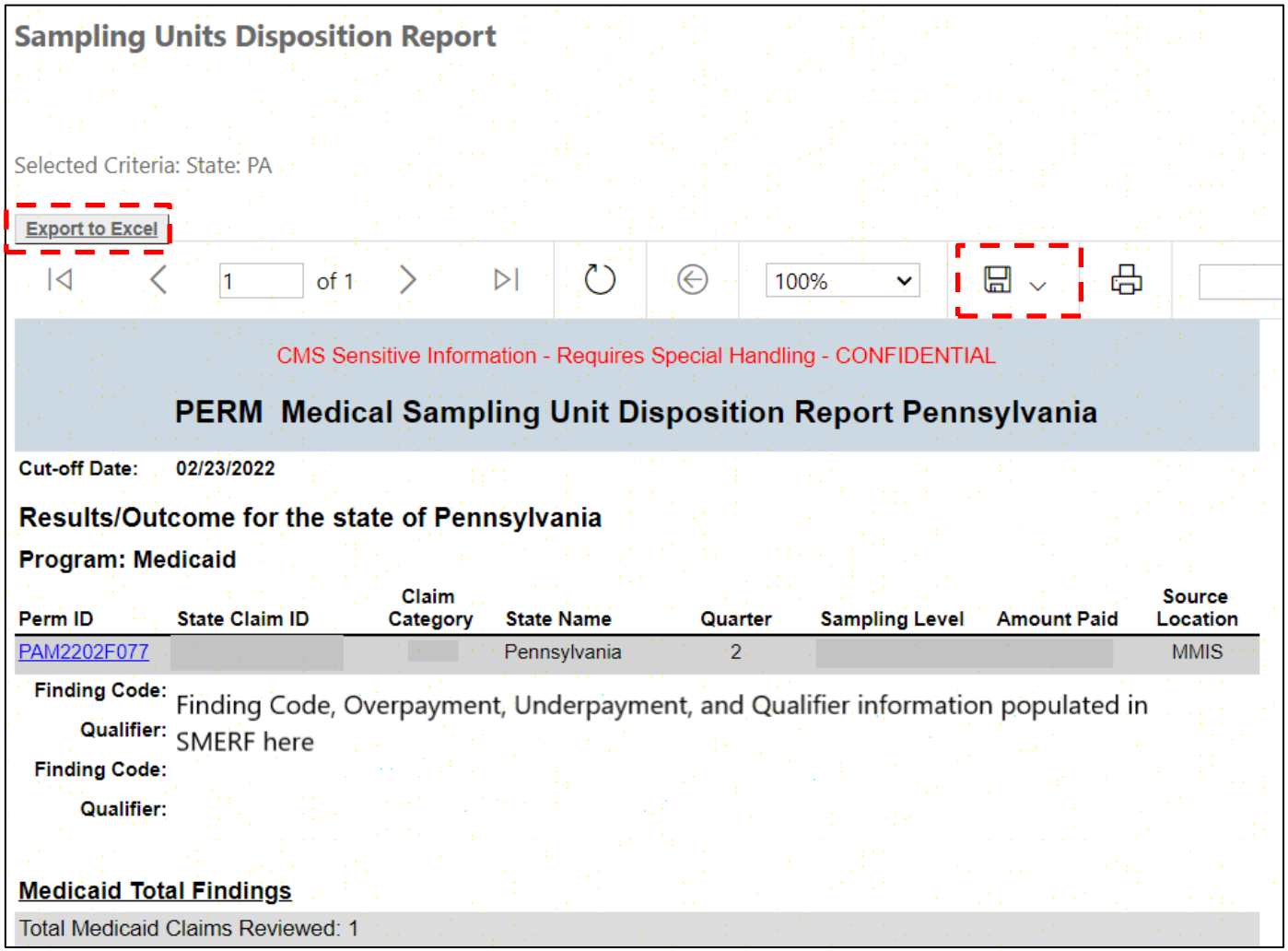
Reports - State SUD - Current

- To view MR current SUD reports, click on Current under the Reports/ State/ SUD menu.



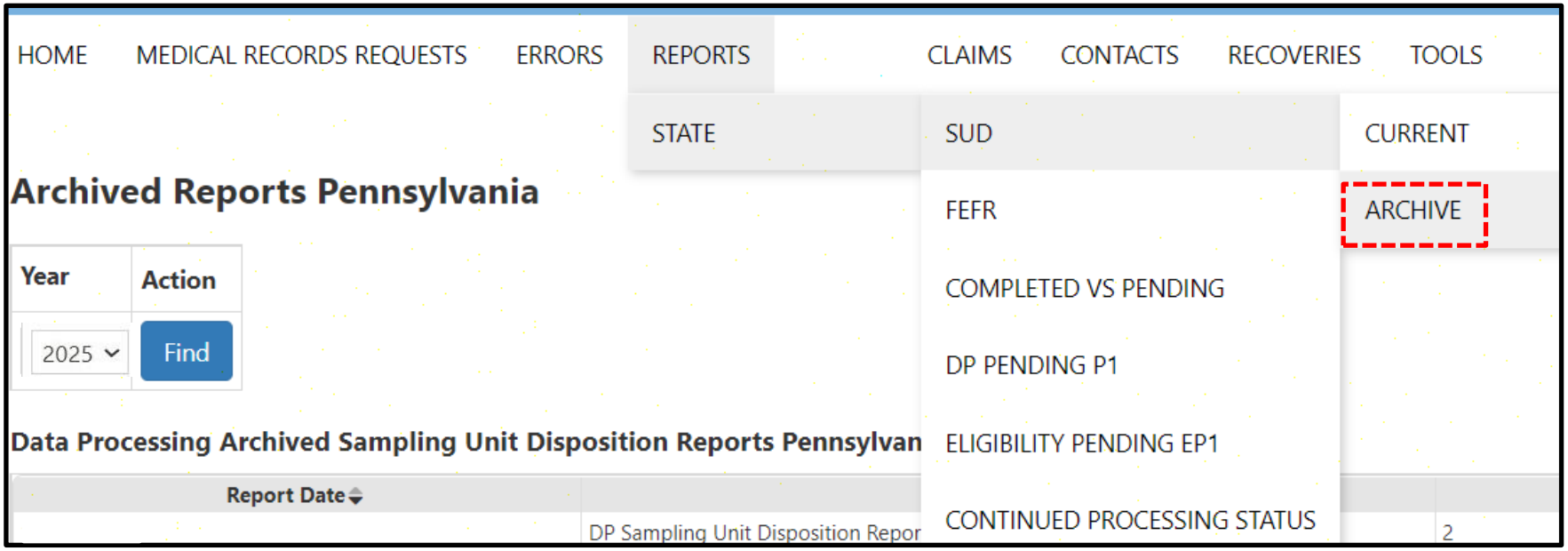
Reports - State SUD – Current, continued

- Click Export to Excel or the Save icon to download the SUD report.



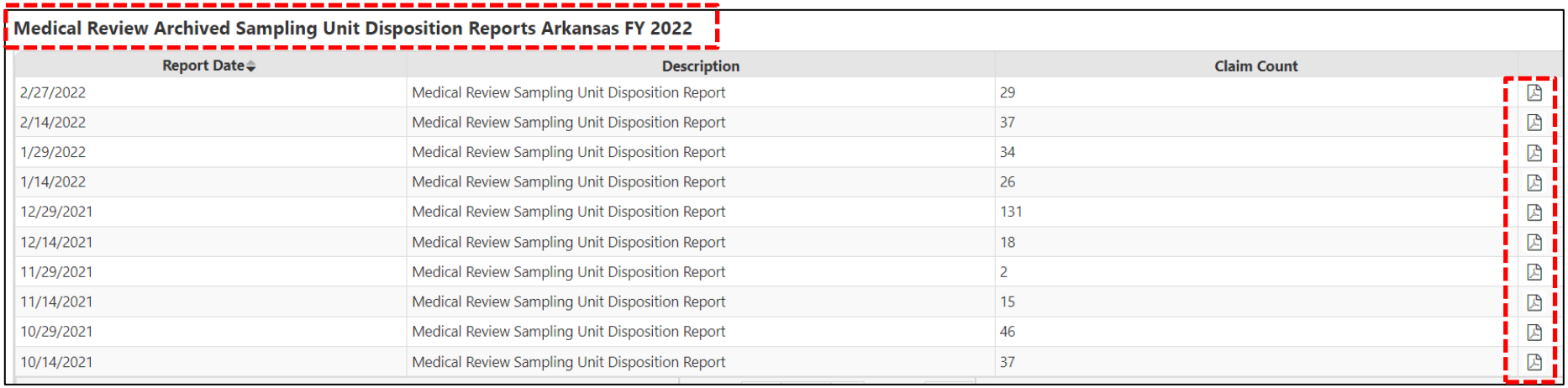
Reports – State SUD - Archived

- To view MR archived SUD reports, click on Archived under the Reports/ State/ SUD menu.



Reports – State SUD – Archived, continued

- For an archived SUD, under Medical Review select the desired report and click the paper icon to download the report.
- Note: Archived reports show the original findings.

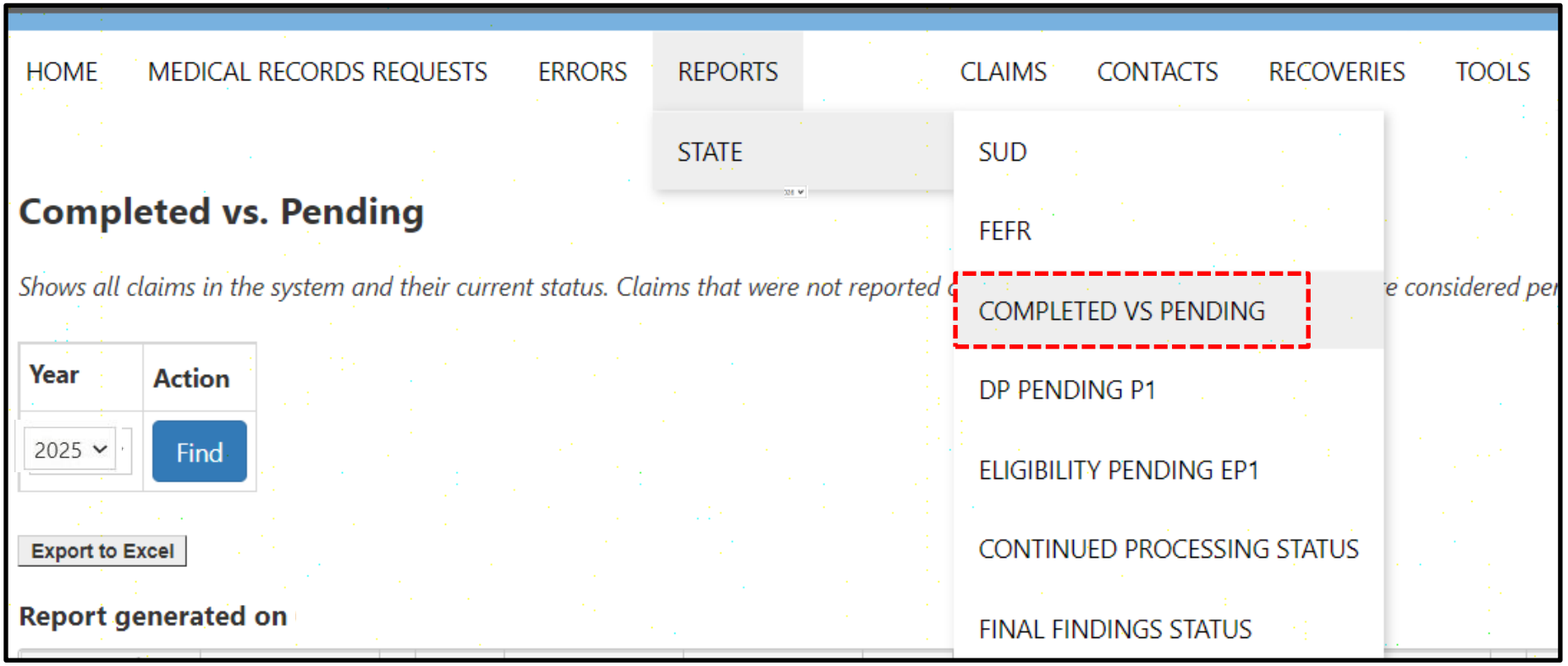


Medical Review Archived Sampling Unit Disposition Reports Arkansas FY 2022

Report Date	Description	Claim Count
2/27/2022	Medical Review Sampling Unit Disposition Report	29
2/14/2022	Medical Review Sampling Unit Disposition Report	37
1/29/2022	Medical Review Sampling Unit Disposition Report	34
1/14/2022	Medical Review Sampling Unit Disposition Report	26
12/29/2021	Medical Review Sampling Unit Disposition Report	131
12/14/2021	Medical Review Sampling Unit Disposition Report	18
11/29/2021	Medical Review Sampling Unit Disposition Report	2
11/14/2021	Medical Review Sampling Unit Disposition Report	15
10/29/2021	Medical Review Sampling Unit Disposition Report	46
10/14/2021	Medical Review Sampling Unit Disposition Report	37

Reports - State Completed vs Pending

- To review all claims in SMERF as well as their current status, click on Completed Vs Pending on the Reports/State menu.



DRs and Appeals

DR

- A state has the right to file a DR to dispute errors cited by the RC per the Code of Federal Regulation, 42 C.F.R. § 431.998.
- States must request the DR within 25 business days after the RC publishes the error on the SUD report. Business days exclude weekends and federal holidays.
- States submit the DR request via SMERF.
  - All MR errors (except MR1*) are eligible for DR, including multiple errors per claim.
  - MR1 errors that arose because providers did not submit requested records to the RC are not eligible for DR; however, states can submit documentation through the end of the cycle at which point the error may be overturned.
  - States can request DR on MR2 errors, and states can also submit documentation through the end of the cycle at which point the error may be overturned.

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

DR, continued

- New SMERF functionality allows states to request DRs for each finding separately within the 25 business day timeframe for each PERM ID when the PERM ID has more than one finding for the same review type.
- For DRs, the state must be able to demonstrate all of the following:
  - The factual basis for filing the request.
  - Provide valid evidence directly related to the finding(s) to support the state's position.
- The state must submit documentation as valid evidence securely through Kiteworks to PERMRC_Docs@empower.ai to support the DR.
  - Do not enter PHI or PII into SMERF or transmit PHI or PII via email.
- The RC reviews the DR and posts the DR decision to SMERF.
- SMERF notifies states via a PERM alert email that the DR decision is available for review (this notification also describes the state's appeal rights).
- This notification starts the Appeals timeframe.

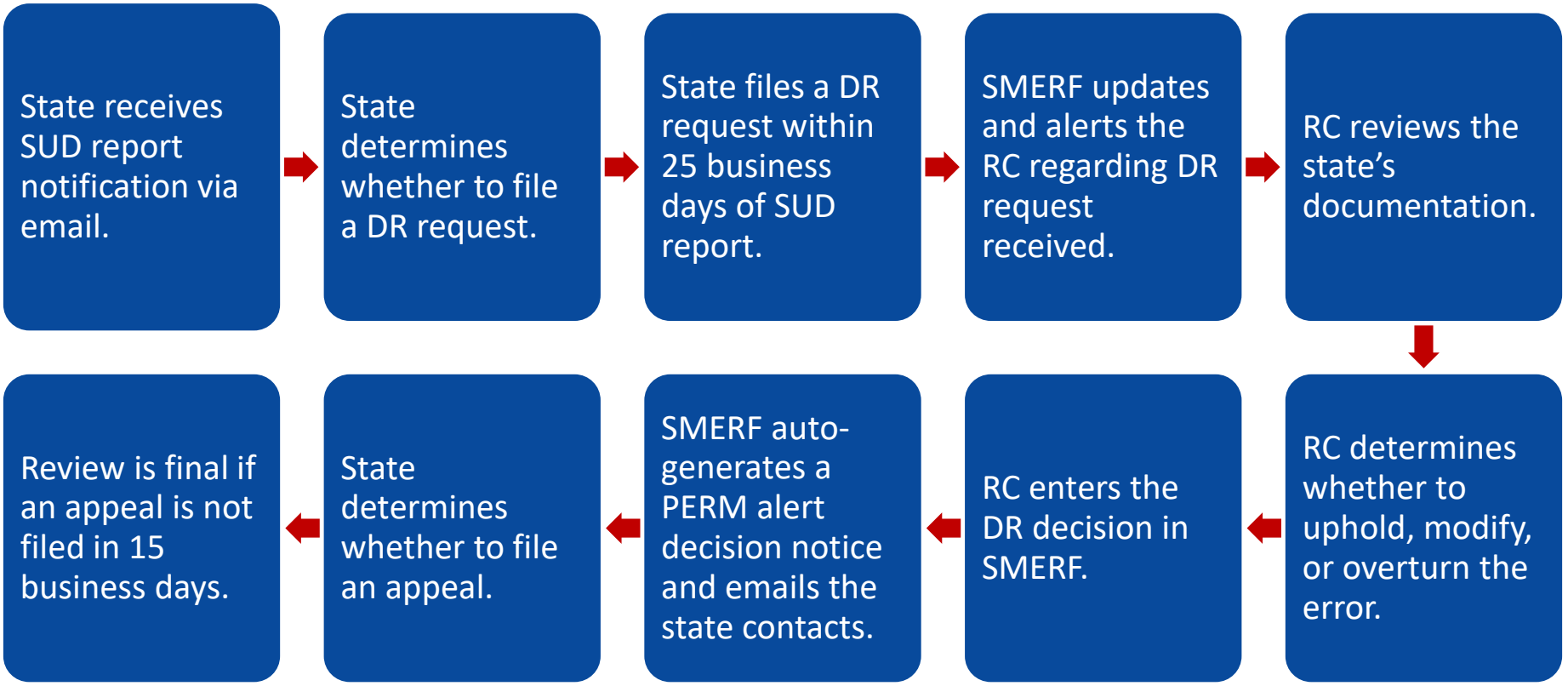
DR Request Considerations

- A DR should be requested when the state:
  - Disagrees with the error finding.
  - Has located additional information it would like the RC to consider.
- States need to include the reason for requesting a DR and/or Appeal in SMERF, rather than just stating the documentation was submitted.
  - The RC encourages states to request DRs on all MR codes except MR1, which allows for repricing of the claim and the correct error amount to be reported.
  - States repricing a claim should include documentation such as fee schedules and calculation steps to support the calculation of correct payment amounts.

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

- No action is necessary if the state is in agreement with the error.
- After 25 business days, states do not have the option to request a DR in SMERF.

DR Request Process



Filing an Appeal

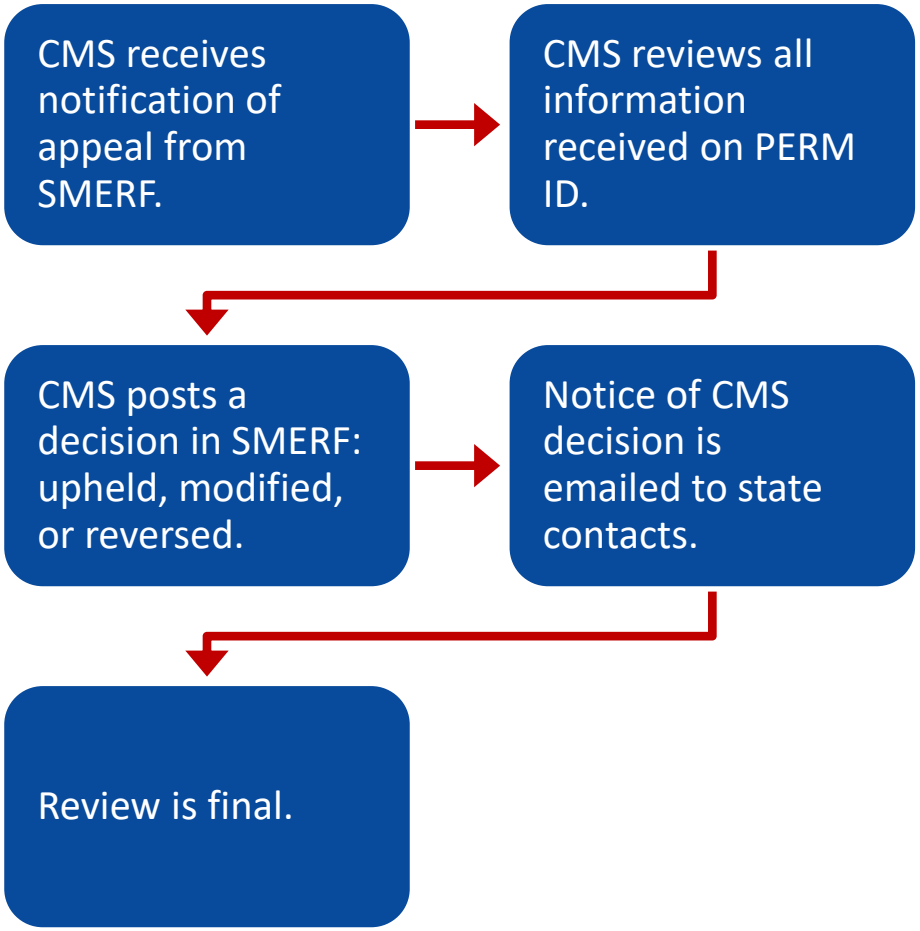
- Appeals must be filed within 15 business days of notification via PERM alert email of the RC upholding or modifying the error decision at DR stage. Business days exclude weekends and federal holidays.
- The state must submit all documentation or evidence relevant to the appeal at the time the appeal is requested (Code of Federal Regulation, 42 C.F.R. § 431.998).
  - The state must be able to demonstrate all of 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.
- New SMERF functionality allows states to request an appeal for each finding separately within the 15 business day timeframe when the PERM ID has more than one finding.

There will be no option to request an Appeal in SMERF after 15 business days following the date of the DR decision.

Filing an Appeal, continued

- If a state submits additional (new) documentation during appeal, it goes back to the DR level and is worked by the RC.
  - If the documentation submitted cannot overturn the error, the appeal request will go to CMS for review.
- States should print the appeals fax cover sheet from SMERF for submission of new MR documentation to the RC (if needed).
- CMS convenes a panel of PERM clinical and policy experts to review appeals.
- Once CMS issues a decision, the state will receive an email notice 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.

Filing an Appeal – Process Flow



- CMS reviews the following information in SMERF:
  - Claim detail.
  - RC original decision.
  - State DR request.
  - RC DR decision.
  - State Appeal request.

State Best Practices

Best Practices for MR

- Collaborate with the RC to create an accurate and complete MPL.
- Communicate with your designated RC Regional Coordinator and CMS PERM State Liaison to obtain immediate resolution of questions or concerns.
- Ensure state PERM representatives and appropriate state subject matter experts participate in check-in calls, orientations, and ad hoc meetings with the PERM RC and CMS.

Best Practices for MR, continued

- Offer PERM educational resources to providers especially providers with sampled services.
- Encourage state team members to be proactive in reaching out to providers for medical records.
- Understand SMERF reports and information available on the SMERF website to track reviews through the continuum.
- Understand PERM timelines and timely response to initial medical records requests and additional documentation requests.

Contacts

Contact Us

For State Use	Contact Information
PERM RC Management Inbox	PERMRC_2026@empower.ai (Not to be shared with providers)
Allison Keeley Medical Records Manager	540-598-7215 keeleya@empower.ai (Not to be shared with providers)
Denise Scavo Medical Review Manager	515-249-0448 dscavo@empower.ai (Not to be shared with providers)
For Provider Use	**Contact Information**
Designated Provider Inquiry Mailbox*	PERMRC_ProviderInquiries@empower.ai (Not to be used for submitting records)
Customer Service Representatives	800-393-3068

* Note: Providers should never send PHI, PII, and/or medical record documentation to the designated provider inquiry mailbox. Providers should use PERM IDs to refer to specific claims.

CMS PERM State Liaisons

Name / States	Email
Alabama, New Hampshire	Anita Moore (anita.moore@cms.hhs.gov)
California, Vermont	Dan Weimer (daniel.weimer@cms.hhs.gov)
Colorado	Ray Antoine (ray.antoine@cms.hhs.gov)
Georgia, Rhode Island	Gwynne Warren (gwynne.warren@cms.hhs.gov)
Kentucky	Misha Patel (misha.patel@cms.hhs.gov)
Maryland	Aileen Almario (aileen.almario@cms.hhs.gov)
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Nebraska, North Carolina	Caitlyn Brown (caitlyn.brown@cms.hhs.gov)
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Tennessee, Utah	Alan Mahmuljin (alan.mahmuljin@cms.hhs.gov)
West Virginia	Jailynne Price (jailynne.price@cms.hhs.gov)

Thanks for your participation!