

Payment Error Rate Measurement (PERM)

PERM Background

The Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program in response to the Improper Payment Information Act, 2002 [IPIA, Public Law 107–300,] enacted November 26, 2002. This act required federal agencies to review programs they oversee that are susceptible to significant improper payments, to estimate the amount of improper payments, to report those estimates to Congress and to submit a report of the actions the federal agency is taking to reduce erroneous expenditures. The Improper Payments Elimination and Recovery Act of 2010 (IPERA) enhances the IPIA of 2002 and aims to further reduce improper payments.

PERM is a comprehensive, ongoing federal audit intended to measure improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP). The two review components to this federal audit are the claims payment review and the eligibility review. Currently all 50 states are being measured over a three-year period. Idaho, along with 16 other states, was chosen to be the first group of states to undergo the federal audit in federal fiscal year (FFY) 2006 and has continued to be a part of the audit on a three-year cycle. At the end of every cycle, which takes approximately 26 months, a state and national payment error rate for the PERM cycle is announced by way of the Department of Health and Human Services (DHHS) report to Congress called the Agency Financial Report (AFR).

PERM is designed to estimate the proportion of Medicaid and SCHIP payments made in error. The estimated payment error rate is calculated as the ratio of the dollar value of all inaccurate payments to the dollar value of the total payments. The dollar amounts (overpayments and underpayments), associated with any errors identified in claims payment or recipient eligibility reviews are tracked and used to calculate the final payment error rate. The state-specific estimates are used to establish national payment error rates for Medicaid and SCHIP. States are required to reimburse CMS for payment errors identified.

How PERM is Conducted

CMS uses national contractors to perform medical records collection, medical records and data processing reviews and to perform statistical calculations. Provider interactions in this process will be primarily with the Review Contractor (RC) who supports PERM by collecting payment related policies from states and medical records from providers. PERM eligibility reviews are conducted by the state.

PERM Medical Records Reviews

Conducting Reviews

- Samples of fee for service (FFS) claims are pulled from all claims paid during the PERM cycle being reviewed.
- The RC will call all providers in the sample to explain the purpose of the call, the right for CMS to collect medical records and identify the appropriate point of contact for each provider.
- The RC 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 request will specify the type of documents that are needed for each claim and will provide instruction on how to submit records to the PERM RC.

Submitting Documentation

- Providers will have 75 calendar days to submit the requested record. Records should be returned with the PERM cover sheet to help easily identify the claim.
- Reminder phone calls and written requests will be sent to providers during this 75 calendar day period if records have not been received. Once records are received the 75 day timeframe will expire.
- If documentation in the record submitted is insufficient to support the claim, additional documentation may be requested before the review is completed. Providers will have 14 calendar days to submit additional documentation.
- A state PERM contact will monitor all PERM activities and will follow-up with providers and CMS contractors regarding the submission of medical records.

Responding to Requests

- All submitted records will be reviewed by registered nurses and certified coders. Determinations will be made of proper payment based on documentation in the record and States' policies for coverage and required documentation.
- All claims with no documentation or insufficient documentation from the provider will be determined to be paid in error.
- If determined an error, Idaho Medicaid will recover the overpayment made to the provider.
- In addition to reimbursing the overpayment, the provider may be required to identify the root cause of the error and submit a corrective action plan on how the provider plans to address the error.

- The Medicaid Fraud Control Unit or the Medicaid Program Integrity Unit may be requested to investigate any cases of suspected fraud or abuse.

Reviewing Medical Records

The RC reviews the medical record to see if a provider (the following list is not an all inclusive list of review areas):

- Responded to the request for documentation within the required time frame.
- Submitted documentation but the documentation did not support the procedure code that was reimbursed.
- Submitted insufficient documentation.
- Submitted a procedure code that was an error (such as, the provider performed a specific procedure but billed using an incorrect procedure code).
- Billed with an incorrect diagnosis.
- Billed for the separate components of a procedure code when only one inclusive procedure code should have been used.
- Billed for an incorrect number of units for a particular procedure or revenue code.
- Billed for a service determined to have been medically unnecessary based on the information in the medical record about the patient's condition.
- Billed and was paid for a service that was not in agreement with a documented policy, regulation or other requirement.

Review Findings and Appeal Rights

The RC will post disposition reports of claims review findings on their website for the State PERM contact to evaluate. The state will follow up with providers to receive any needed clarifications. The state can file a notice that it disagrees with the error findings and provide supporting evidence that the claim was correctly paid. The RC will re-review the claim with the supporting documentation and reverse or uphold the findings. If the state agrees with the error findings and an overpayment has occurred, the state will pursue recovery of the improper payment from the provider. Providers will still have normal appeal rights with the state.

Submission Mistakes

- Not responding within the required timeframes.
- Submitting records for the right patient but for the wrong dates of service.
- Submitting records for the wrong patient.
- Not submitting readable records – e.g., poor quality of faxed documents.
- Not copying both sides of two sided pages.

- Marking/highlighting certain parts of the record which obscures important facts when copied.

Provider Best Practices

- Is knowledgeable about Idaho's Medicaid policies for their provider type.
- Monitors Idaho's Website for policy updates.
- Maintains documentation required by Idaho's policies.
- Makes the medical record request a priority and begins to process it when received.
- Reads the request thoroughly, paying close attention to the dates of service requested.
- Designates a point of contact to handle audit requests.
- Researches thoroughly with appropriate departments if unable to locate patient or date of service requested.
- Assures that patient's name on record is the same as on the claim sampled.
- Cross references name changes, including newborns.
- Monitors photocopy service turnaround and quality of PERM requests.
- Understands that sending billing information is not sufficient proof that services were provided.
- Understands the importance of submitting records requested no matter how small the amount that was paid.
- Maintains a copy of documentation for services performed elsewhere that supports the claim.
- Understands that if it wasn't documented, it wasn't done

Additional PERM Information

- CMS Website – <http://www.cms.hhs.gov/PERM>
- Agency Financial Report of annual improper payments -<http://www.hhs.gov/afr/>
- Providers may email their State PERM contact at SchellB@dhw.idaho.gov or CMS at PERMProviders@cms.hhs.gov for any provider specific questions.