PERM - Difference Resolution Process

A Process to Ensure Accurate Claims Review Findings

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Introduction

The Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, enacted on November 26, 2002, requires the heads of Federal agencies to review annually programs they oversee that are susceptible to significant erroneous payments, to estimate the amount of improper payments, to report those estimates to the Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures. The Office of Management and Budget (OMB) identified Medicaid and the State Children's Health Insurance Program (SCHIP) as programs at risk for significant improper payments. More information on the PERM program can be accessed at http://www.cms.hhs.gov/PERM.

To implement the requirements of IPIA, CMS developed the Payment Error Rate Measurement (PERM) program. Under PERM, reviews will be conducted in three areas: (1) fee-for-service (FFS), (2) managed care, and (3) program eligibility for both the Medicaid and SCHIP programs. The results of these reviews will be used to produce national program error rates, as required under the IPIA, as well as State specific program error rates. Because States administer Medicaid and SCHIP and make the payments for services rendered under these programs, it is critical that the States participate in the measurement process. CMS will use PERM to measure Medicaid and SCHIP improper payments in a subset of 17 States each year. To enable States to plan for the reviews, States will be reviewed on a rotating basis. Each State will be measured for improper payments for both programs once and only once every three years.

Review Contractor

CMS has developed a national contracting strategy for measuring improper payments made in FFS and managed care for both Medicaid and SCHIP. To that end, CMS engaged a review contractor (RC) to conduct medical and data processing reviews of the FFS claims as well as data processing reviews of the managed care capitation payments in each program. Managed care capitation payments are not subject to medical review because the payments are based on a benefit package rather than on a specific service. The State will conduct the eligibility reviews and calculate and report a payment error rate.

Difference Resolution Process

The difference resolution process is the means by which a State can dispute the RC's medical and data processing error findings and present evidence to support the State's belief that the claim was correctly paid.

To implement this process, the RC will post monthly disposition reports of claims review findings on its website for States to review and determine whether they agree with the

error determinations. 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 together with the State's documentation and either reverse or uphold its findings. States will have certain appeal opportunities to CMS for final claims disposition.

Disposition Reports

Disposition reports contain information on the RC's findings of the data processing and medical reviews of the FFS claims and the data processing review findings of the managed care claims. The RC will post State-specific disposition reports for each State being measured in the relevant fiscal year on its web site. Details on the web site location will be provided by the RC.

The RC will post disposition reports on a monthly basis until the second April of the production cycle.[1] Thereafter, the RC will provide reports on the 15th and 30th of each subsequent month until June 1. States will be notified via e-mail when a disposition report is available for viewing. The website is confidential and designed so that States do not have access to other States' information.

The disposition report will contain the findings on the data processing and medical reviews. States can choose to dispute both the data processing review error findings and the medical review error findings. Most likely, the majority of the findings on the data processing reviews will be posted before the majority of the medical reviews because the processing reviews are conducted on the claims at once whereas the medical reviews are conducted on a flow basis as the medical records are obtained.

Since the data processing and medical reviews are conducted independently, the initial error amounts will be determined separately for purposes of the difference resolution. However, it is possible that a claim can have both a data processing error and a medical review error. When final findings are reported to the statistical contractor, all error amounts per claim will be taken into consideration but the total error amount on any claim will not exceed the total paid amount.

The disposition report will detail the RC's findings for each claim reviewed in the previous month as follows:

- The claim identifying information (i.e. assigned control number);
- Data processing review determination findings;
- Medical review determination findings, (for fee-for-service claims);
- Correct paid amount or improper paid amount of an error; and,
- Reason for error, as applicable.

[1] For purposes of PERM, a "production cycle," consists of approximately 23 months. For example, the measurement for FY 2007 (which involves the reviews of Medicaid and SCHIP claims from October 2006 through September 2007) begins October 1, 2006 and ends August 30, 2008 when error rates are calculated.

Simultaneous to the release of the monthly disposition report, the documentation/database contractor (DDC) will provide a password-protected compact disc (CD) to each State that contains the medical records associated with the FFS claims cited with medical review errors. A State can use the medical records to evaluate whether it agrees with the RC's finding or file a notice of difference in finding.

State Process to File a Notice of Difference in Finding

If a State disagrees with an error finding, it should file a *Notice of Difference in Finding* on the RC's web site within 10 business days from the posting date of the disposition report for the claim. The State's request will be dated and recorded in the website to validate that the request was made within 10 business days of the posted disposition report. Be advised that notices filed after the 10 day timeframe will not be included or considered in the difference resolution process. Therefore, we recommend that every State designate a secondary State person as back-up to the primary State person responsible for tracking/monitoring/responding to error findings for each program so that each State will be able to respond to the findings in the event the primary person is unavailable.

Under extraordinary circumstances that cause a delay of at least 5 business days of the 10 business day period for a State to determine whether to rebut the error finding, the State may request to have a new 10 day timeframe for filing the Notice of Difference in Finding. The State has to initiate the request in such circumstances within 3 business days from the date of the error posting on the disposition report. The request should be made to the RC's PERM Director; their contact information is available on the CMS PERM website at: http://www.cms.hhs.gov/PERM/03_permprocess.asp#TopOfPage. An example of extraordinary circumstance would be when the CD containing the medical records being delivered to the State was delayed due to air traffic control problems.

The State may file a Notice of Difference in Finding for the following reasons:

- A claim has a medical review related error coded (MR 2-9 as defined in the Appendix) or a data processing related error coded (DP 1 -10 as defined in the Appendix); and,

- There is an impact on payment, i.e., the payment amount in error would change. For example, zero paid claims would not be eligible for difference resolution.

When the above conditions are met, the State may file a Notice of Difference in Finding based on evidence that one or more of the following occurred:

- A policy was applied in error;
- A policy that was in effect at the time of service was not considered during the review (includes updates to current policies but excludes new policies developed after the end of the quarter under review and made effective retroactive to the quarter);

- The error finding was not justified by the evidence provided to the reviewer; and/or
- The claim is in error but the payment amount in error is overstated or understated.
- The State can demonstrate that the claim should only have been subject to a data processing review rather than a medical review;
- The State can demonstrate that the claim was for a managed care enrollee and not eligible for a medical review;
- The State can demonstrate that the claim was erroneously included in the universe and/or sample, e.g. the claim was paid with 100% State funds.

When filing a *Notice of Difference in Finding*, the State will need to provide: (1) the reason why the State believes the claim was correctly paid; and (2) the factual basis, substantiated by valid and convincing written evidence, supporting the reason why the claim was correctly paid. Valid and convincing written evidence is information that was contained or should have been contained in the medical records at the time of the review, policies in effect at the time of service (including updates to current policies but excluding policies developed after the end of the quarter under review and made effective retroactive to the quarter) or evidence that the claim should not have been subjected to a medical review. Evidence must be limited to no more than 5 pages of written documentation, including links to websites or other references to sources, to ensure that excessive time is not spent reviewing voluminous documentation. Evidence exceeding this limitation will not be considered in the final evaluation.

The State may not file a Notice of Difference in Finding based upon:

- Adjustments made to claims outside of 60 days from adjudication. The difference resolution process is not intended to extend the 60-day timeframe for adjustments. Therefore, subsequent adjustments to claims will not be considered as a valid reason to reverse findings on claims.

- Claims with findings of “no documentation” (MR1) errors due to providers not submitting the requested information within the timeframe allowed. States can follow-up with providers during the collection of medical records to ensure providers submit the necessary documentation within the allowed timeframe.

- Operating State policies that are unwritten or conflict with the State’s plan or Federal rules.

- Policies developed after the end of the quarter under review and made effective retroactive to the quarter.

Requests for difference resolutions that do not adhere to the criteria set forth in this section will not be considered. Also, States should not commingle MR1 errors with MR2 – MR9 errors to ensure that errors eligible for difference resolution are not inadvertently dropped from the process.

Determination of Error Finding

The RC will review the State's reason(s) for the difference in finding together with the evidence submitted and render a final determination within 15 business days from the date the State's notice was filed. The State can access the RC's web site to view the posted determination.

If the RC agrees with the State that the claim was properly paid, the error finding will be reversed. If the RC upholds its error determination, the State may request reconsideration from the RC if there are compelling reasons. For example, there are two identical errors, but one decision is reversed while the other is upheld. Requests for reconsideration of errors without a compelling reason will not be granted. The reconsideration of errors is at the RC's discretion.

State Appeal to CMS

States may appeal to CMS error findings upheld by the RC on claims where the difference in findings is in the amount of $100 or greater. It is important to note that the difference amount must be $100 or greater, not the actual dollar amount on the claim in error.

> *Example 1: $300 is the paid claim amount, but $250 should have been paid, leaving $50 as the difference in finding making the claim ineligible for appeal.*
>
> *Example 2: $300 is the paid claim amount, but $100 should have been paid, leaving $200 as the difference in finding making the claim eligible for appeal.*

States may appeal the RC's determination to CMS through the RC's web site within 5 business days from the date the RC finding as a result of the difference resolution is posted. The State's reasons for difference resolution and the RC's justification for upholding its initial error finding already will be available to CMS on the RC's website. CMS will make the final determination on the sampled claim and post notice its findings on the RC's website within 30 days of the State's request for appeal. The RC will send an email to the State to access the RC's web site to view CMS' decision on the appeal. There will be no further judicial or administrative review of CMS' decision; the CMS decision is final.

Refund of Federal Matching Funds

The PERM program does not include new recovery requirements of the Federal portion of Medicaid and SCHIP improper payments. Medicaid and SCHIP recovery requirements are longstanding as outlined in Federal regulations at 42 CFR 433.300 and 42 CFR 457.232 respectively.

For purposes of PERM, for FY 2007 and beyond, States are considered to be officially notified by CMS of identified improper payments by the posting of Medicaid and SCHIP errors on the RC's website on the first business day of each month (once medical and data processing reviews commence). The website postings contain the errors that have completed the difference resolution and CMS appeals process, as applicable, and the error findings were upheld. These postings will be separately identified from claims posted for initial difference resolution. For Medicaid, this notification begins the 60-day timeframe for refunding of overpayments on the error claims. This posting of SCHIP claims in error also serves as the official CMS notification for the refunding of overpayments in SCHIP, which are to be refunded on a quarterly basis. States should follow the current CMS process for refunding Federal payments.

Impact on State Error Rate

If the State does not file a *Notice of Difference in Finding* within 10 business days from the posting date of the disposition report, the RC's finding will be submitted to the statistical contractor for inclusion in the State's error rate.

It is possible that *Notices of Difference in Finding* that States file based upon disposition reports posted after the second April in the production cycle may not be resolved prior to the July 15 cut-off date for reviews; which is necessary to commence the error rate calculation. All differences in findings between the State and the RC not resolved by July 15 will be considered improper payments and included in the error rate calculation. All appeals to CMS that have not been finalized as of July 15 will also be considered improper payments for purposes of the error rate calculation. However, States may request resolution of unresolved error findings after August 30 and may request the CMS statistical contractor calculate a new error rate based on resolution of the outstanding differences.

Recalculation of the State Error Rate

A State may request a new error rate calculation from the statistical contractor based on resolution of outstanding differences when the expected impact of the change in the error rate is at least 0.25 percentage points. The request for recalculating the error rate must be made within 60 business days of the posting date of the State's program error rate on the RC's website.

To request a recalculation of the error rate, the State must contact the statistical contractor in writing. The statistical contractor will advise States on this process.

When the outstanding differences are resolved, the RC will send a revised list of errors on which to recalculate the error rate. The statistical contractor will notify the State by e-mail of its revised error rate within 30 business days of receipt of the revised error list from the RC.

Appendix

Data Processing (DP) and Medical Review (MR) Error Codes

The following are data processing error codes:

- DP1 – Duplicate item: An exact duplicate of the sampling unit was paid.
- DP2 – Non-covered service: State policies indicate that the service is not payable under the State plan or for the coverage category under which the person is eligible.
- DP3 – FFS claim for a Managed care service: The beneficiary is enrolled in a managed care plan and the service is covered under the managed care plan. The claim is not properly paid under FFS.
- DP4 – Third-party liability: A third-party insurer is liable for all or part of the payment.
- DP5 – Pricing error: Payment for the service does not correspond with the pricing schedule for that service.
- DP6 – Logic edit: A system edit was not in place based on policy or a system edit was in place but was not working correctly and the sampling unit was paid (e.g., incompatibility between gender and procedure, or ineligible beneficiary or provider).
- DP7 – Data entry error: Clerical error in the data entry of the sampling unit.
- DP8 – Rate Cell error: The beneficiary was enrolled in managed care and payment was made, but for the wrong rate cell.
- DP9 – Managed Care payment error: The beneficiary was enrolled in managed care, but was assigned the wrong payment amount.
- DP10 – Administrative/Other: A payment error was discovered during a data processing review but the error was not a DP1 – DP9 error.

The following are medical review error codes:

- MR1 – No documentation: The provider did not respond to the request for records within the 60-day timeframe.
- MR2 – Insufficient documentation: The medical record does not contain sufficient evidence to verify proper payment. The provider submitted additional documentation as requested but it did not support the procedure code that was reimbursed, or the provider did not respond to the request for additional documentation.
- MR3 – Procedure coding error: The provider performed a procedure but billed using an incorrect procedure code.
- MR4 – Diagnosis coding error: The provider billed an incorrect diagnosis.
- MR5 – Unbundling: The provider billed for the separate components of a procedure code when only one inclusive procedure code should have been billed.
- MR6 – Number of unit(s) error: The provider billed for an incorrect number of units for a particular procedure or revenue code. This error code does not include claims where the provider billed for less than the allowable amount, as provided for in written State policy.

- MR7 – Medically unnecessary service: The provider billed for a service determined to have been medically unnecessary based upon the information regarding the patient's condition in the medical record.
- MR8 – Policy violation: Either the provider billed and was paid for a service that was not in agreement with a documented policy, or the provider billed and was not paid for a service that, according to policy, should have been paid.
- MR9 – Administrative/Other: A payment error was discovered during a medial review but was not a MR1 – MR8.