CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Medicaid and CHIP Providers: Understanding Your Responsibilities to the Payment Error Rate Measurement (PERM) Program

PERM Overview for Providers

Division of Payment Error Rate Measurement

Payment Accuracy & Reporting Group

Office of Financial Management

Centers for Medicare & Medicaid Services

Overview

- The PERM program is designed to measure and report improper payments in the Medicaid and CHIP programs.
- The purpose of educating providers and suppliers about PERM is to provide opportunities for those participating in the Medicaid and CHIP programs to better understand:
  - The PERM program.
  - The PERM medical review process.
  - PERM medical record and documentation requests.
  - Methods for record submission.
  - Provider best practices.
  - PERM resources for providers.
- Please send any questions you have to the PERM resource mailbox via email at: PERMRC_ProviderInquiries@nciinc.com.

Purpose

- The purpose of this presentation is to educate the provider community about the PERM program and to explain your responsibilities as participants in Medicaid and/or CHIP.

PERM Background

The Payment Integrity Information Act (PIIA) of 2019, requires heads of federal agencies to annually review programs that they administer to:

- Identify those that may be susceptible to significant improper payments.
- Estimate the amount of improper payments.
- Submit those estimates to Congress.
- Submit a report on corrective actions the agency is taking to reduce improper payments.

The Office of Management and Budget (OMB) has identified Medicaid and CHIP as programs at risk for significant improper payments. As a result, CMS developed the PERM program to comply with the PIIA and related guidance issued by OMB.

PERM Background, continued

- The purpose of the PERM program is to measure and report a national improper payment rate for Medicaid and CHIP in order to comply with the requirements of the PIIA.
- Improper payment rates are based on reviews of Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the RY-under review.
- The improper payment rate is not a “fraud rate” but a measurement of payments made that did not meet statutory, regulatory, or administrative requirements. These improper payments may be overpayments or underpayments and do not necessarily represent expenses that should not have occurred.
- CMS and HHS report improper payments annually in the Agency Financial Report (AFR), located at http://www.hhs.gov/afr/.

Definition of Improper Payments

- Improper payments are payments that should not have been made or payments made in an incorrect amount.
- Improper payments include:
  - Payments made on behalf of an ineligible beneficiary.
  - Payments for an ineligible service.
  - Duplicate payments.
  - Payments for services not received.
  - Payments for an incorrect amount.
  - Payments for services where there is a lack of supporting documentation necessary to verify the accuracy of a payment.
  - Payments for services not medically necessary.

PERM Measurement Cycles

CMS uses a 17 or 18 state rotational approach to review the states' Medicaid program and CHIP so that the PERM program measures each state once every three years.

The following is a list of states and their assignment within the rotation cycles:

- **Cycle 1** - Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming.
- **Cycle 2** - Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia.
- **Cycle 3** - Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, Puerto Rico, South Dakota, Texas, Washington.

*State is used collectively to refer to states, the district, and territory.

PERM Measurement Cycles, continued

Reporting Year (RY)	Rotation Cycle*	Payments Under Review
RY2026	2	Medicaid and CHIP FFS payments made by states beginning July 1, 2024, through June 30, 2025
RY2027	3	Medicaid and CHIP FFS payments made by states beginning July 1, 2025, through June 30, 2026
RY2028	1	Medicaid and CHIP FFS payments made by states beginning July 1, 2026, through June 30, 2027
RY2029	2	Medicaid and CHIP FFS payments made by states beginning July 1, 2027, through June 30, 2028
RY2030	3	Medicaid and CHIP FFS payments made by states beginning July 1, 2028, through June 30, 2029

*Previous slide lists states under review in each rotation cycle.

PERM Measurement Components

CMS reviews the following three components of Medicaid and CHIP:

- **Fee-For-Service (FFS):**
  - Sample consists of FFS claims.
  - Federal contractors conduct medical reviews, eligibility reviews, and data processing reviews on sampled FFS claims.
- **Managed Care:**
  - Sample consists of at-risk capitated payments.
  - Federal contractors conduct data processing and eligibility reviews on sampled managed care payments.
- **Eligibility:**
  - Sample consists of beneficiaries.
  - Federal contractor conducts eligibility reviews for beneficiaries on sampled claims.

PERM Partners and Their Responsibilities

Role	Responsibility
Provider	• Verifies beneficiary Medicaid or CHIP eligibility is active for the date of service as appropriate. • Maintains complete and thorough documentation for services provided. • Submits requested records to the PERM Review Contractor (RC) within the required timeframe – 75 days for initial requests for records and 14 days for requests for additional documentation. • Provides all relevant documentation listed on the Request for Records Cover Sheet included with the records request. • Responds in a timely manner to outreach from the state PERM representative and PERM RC regarding medical record requests and documentation.

PERM Partners and Their Responsibilities, continued

Role	Responsibility
State PERM Representative	• Serves as the state's central point of contact and coordinates state PERM activities. • Educates providers on the PERM process and assists with medical record collection.
PERM RC	• Conducts data processing reviews on FFS and managed care claims. • Requests all medical record documentation associated with the randomly selected sample of Medicaid and CHIP FFS claims. • Conducts medical reviews on FFS claims.

PERM Medical Review Process

- CMS uses a PERM RC to conduct a medical review of FFS payments to determine the appropriateness of the payment.
- NCI Information Systems, Inc. is the current PERM RC.
- The PERM RC requests medical records from the provider for all FFS claims sampled.
  - The random sample pulls from all Medicaid and CHIP FFS payments a state makes in the year under review.
  - Providers and suppliers who received FFS payments in the year under review may or may not be selected for PERM medical review.
- Medical review includes review of the following to determine whether the service was medically necessary, provided in the appropriate setting, billed correctly, and coded accurately:
  - Provider's medical record supporting the service(s) claimed.
  - Code of Federal Regulations applicable to conditions of payment.
  - State's written policies and guidelines.

Medical Record/Documentation Requests and Provider Best Practices

Medical Record/Documentation Requests

- PERM RC customer service representatives (CSRs) will call all providers in the sample to:
  - Describe the purpose of the request.
  - Explain the authority for CMS to collect medical records for audit purposes.
  - Identify the appropriate point of contact for each provider and contact information such as mailing address or fax number.
  - Determine if the provider prefers to receive the records request by fax in addition to mail.
- The PERM RC will fax/mail a written request to the provider's office after verifying:
  - The correct provider has been reached.
  - The location of the medical record needed.

Medical Record/Documentation Requests, continued

- PERM CSRs will send the initial medical records request letter and all follow-up letters for the sampled claim(s) to the established point of contact for the provider.
  - Medical records request letters include the PERM RC customer service telephone number, the Medical Records Manager’s name and telephone number, a PERM RC email address for provider inquiries, and the name and contact information for the state PERM representative.
  - Letter packets also include the beneficiary's name, sampled date(s) of service, diagnosis code, procedure code, and amount paid. As applicable, the letter packet includes the National Drug Code (NDC), prescription (Rx) number, and Diagnosis Related Group (DRG). A general list of requested documentation per claim type and claim category will be included on the Request for Records Cover Sheet.

Medical Record/Documentation Requests, continued part 2

- The medical records request letter packet consists of the following documents:
  - Initial Request for Records.
  - Request for Records Cover Sheet.
  - Claim Summary.
  - Provider Record Submission Instructions.
- Please note that the PERM RC uses a Request for Records Cover Sheet specific to the claim type and claim category.

Timeframes (Initial Request)

- Requests for provider medical records associated with sampled FFS claims for a review cycle will begin in the second March/April of each cycle and continue through the third March of the cycle.
- Providers will have 75 calendar days from the date of the request letter to submit the record to the PERM RC.
- During the 75 calendar days, the PERM RC conducts reminder phone calls and sends written requests to providers at day 30, day 45, and day 60 if records are not received.
- The PERM RC sends a 75-day final notice of non-response letter to providers if records are not received indicating State Agency officials may seek recovery of the payment for the claim from providers.
- The PERM RC notifies the state PERM representative when documentation is submitted or has not been received timely.

Timeframes (Additional Information Requests)

- If documentation submitted is incomplete to support the claim, the PERM RC requests additional documentation.
- Providers have 14 calendar days from the date of the request letter to submit this additional documentation.
- The PERM RC provides specific details identifying additional documentation needed both verbally and in writing.
- The PERM RC conducts reminder calls and sends reminder letters at the 7-day mark.
- The PERM RC sends a 15-day final notice of non-response letter to providers if records are not received indicating State Agency officials may seek recovery of the payment for the claim from providers.
- The PERM RC notifies the state PERM representative when documentation is submitted or has not been received timely.

Importance of Submitting Complete Patient Records

- **Errors:** The PERM RC determines all claims with no documentation or incomplete documentation from the provider to be paid in error.
- **Sanctions:** If a claim is determined to be in error, State Medicaid Agencies may pursue recovery of payment for this claim from the provider.
- Accurate PERM measurements rely on cooperation from providers in submitting documentation.
- The PERM RC cannot make a correct finding of proper payment without the medical record from the provider.
- All records, even those for low dollar claims, are equally important for accurate PERM measurement.

Provider Best Practices Prior to Submitting Records

- Contact PERM RC CSRs by phone at 800-393-3068 or by email at PERMRC_ProviderInquiries@empower.ai as soon as possible with questions or concerns regarding the medical records request. Do not send medical records, Protected Health Information (PHI), or Personally Identifiable Information (PII) to this email address.
- Check state policies and guidelines to ensure records submitted include all required documentation for the correct beneficiary and correct sampled date(s) of service.
- Inform staff and, if applicable, the Release of Information (ROI) contractor about PERM.
- Verify records submitted are complete, legible, and include all relevant documentation to support the sampled claim.
- Ensure that each page lists the beneficiary name and that at least one page lists both beneficiary name and date of birth.

Provider Best Practices Prior to Submitting Records, continued

- Read the entire PERM RC medical records request letter packet and make note of the following:
  - The list of requested documents per provider type.
  - The beneficiary name and sampled date(s) of service.
  - The due date – 75 calendar days for initial records requests and 14 calendar days for additional documentation requests.
- Verify that the letter is legitimate by reviewing the PERM Contractor Contact List on the PERM Contacts page of the CMS website.
- Reply to the request for records as soon as possible and do not wait until the due date. This action ensures:
  - Provider avoids reminder calls and follow-up letters.
  - Timely record collection for PERM measurement.

Provider Best Practices When Submitting Records

- Follow provider record submission instructions listed on the final page of the letter packet.
- Place the Request for Records Cover Sheet as the first page on all record submissions.
- If submitting by fax, indicate the number of pages in the submission on the cover sheet to help the PERM RC confirm complete transmission of records.
- Contact the PERM RC after submission by email at PERMRC_ProviderInquiries@nciinc.com to confirm receipt of records.

*Do not send medical records, PHI, or PII via email.

Provider Best Practices When Submitting Records, continued

- Providers may submit records by fax or mail to the PERM RC.
- Providers may utilize Electronic Submission of Medical Documentation (esMD) to submit the records.
  - esMD is a fast and reliable method for submitting records to the PERM RC.
  - Please visit the esMD for Medicare Providers and Suppliers website for more information.
  - Please click the following link for more information regarding esMD later in this presentation: Electronic Submission of Medical Documentation (esMD) System.
- State PERM representatives may also assist with record collection.

Provider Best Practices

When Responding to Additional Documentation Requests

- Read the additional documentation request letter and review the specific requested documentation located on the Request for Records Cover Sheet carefully to determine the exact additional documentation needed by the PERM RC.
- Contact PERM CSRs by phone at 800-393-3068 or by email at PERMRC_ProviderInquiries@nciinc.com as soon as possible with any questions or concerns regarding the request.
- Submit the requested additional documentation within 14 calendar days from the date of the request letter.
- The due date will be noted on the additional documentation request letter.

Provider Best Practices
When Responding to Additional Documentation Requests, continued

- Do not resubmit records previously submitted unless specifically requested to do so, e.g., the PERM RC received illegible records and needs a legible copy.
- Pay particular attention to what the PERM RC requests and what was missing from the original submission.
- Take immediate action upon notification of incomplete information.
  - If the PERM RC determines additional documentation submitted is incomplete, the PERM RC sends a Receipt of Incomplete Information letter.
  - The letter lists the exact nature of the missing information.
  - The purpose of this letter is to give providers a final chance to submit the requested records before the PERM RC cites an error.
  - If you are unsure of what is being requested, please contact the PERM RC by phone at 800-393-3068 or by email at PERMRC_ProviderInquiries@empower.ai for more information.

Provider Best Practices
Preventing Resubmission Request Letters

- Resubmission requests will be sent to providers when the submitted records have errors that disqualify records from medical review.
- CSRs will contact the provider, explain the error found in the records, and request that the provider resubmit records.
- Best practices to prevent resubmission requests include submitting:
  - Legible copies of records.
  - Records for the correct beneficiary.
  - Records for the correct date(s) of service.
  - Records that include the beneficiary's name on each page and beneficiary's date of birth on at least one page.

Provider Best Practices Reminders

- Do not submit any information containing PHI to the PERM RC via unsecure email. The PERM RC does not accept provider record submissions via email.
- The PERM RC is not authorized to reimburse providers or suppliers for the cost of copying or mailing records. The PERM RC does not accept invoices from providers, release of information contractors, or copying services.
- As needed, contact the state PERM representative listed on the PERM medical records request letter to:
  - Update provider contact information in the state claims system.
  - Receive information on recoveries for billing errors.
  - Discuss any confidentiality or privacy concerns regarding medical record submission to the PERM RC.

PERM Contact Information for Providers

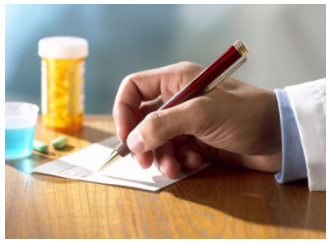
Submit Records by Fax to PERM RC:
1-804-515-4220

PERM RC Email Address for Provider Questions:
PERMRC_ProviderInquiries@empower.ai
Please send all provider questions to this email address, but do not send records, PHI, or PII.

PERM RC Customer Service Representatives:
800-393-3068

PERM RC Medical Records Manager:
Allison (Allie) Keeley
804-249-1746

Electronic Submission of Medical Documentation (esMD) System



Introduction - Background

- The Medicaid/CHIP Programs make billions of dollars in estimated improper payments.
- CMS employs several types of RCs to measure, prevent, identify, and correct these improper payments.
- Over 2 million medical documentation requests or Additional Documentation Requests (ADRs) are sent annually by CMS RCs.
- Historically, the provider responded with the requested documentation via mail or fax.

What is esMD?

- The esMD system was implemented in September 2011 as an additional option for Medicare FFS providers to send medical documentation electronically to CMS Medicare RCs.
- The esMD system is comprised of a CONNECT Gateway, which is capable of exchanging documents with other CONNECT compatible gateways. The gateways are built in accordance with the Office of the National Coordinator (ONC) for Health Information Technology (HIT) standards.
- The esMD system facilitates the secure exchange of medical documents from Providers' HIT systems via Health Information Handlers (HIHs) to the CMS CONNECT Gateway.
- esMD also allows for the secure exchange of documentation between RCs.

Benefits of esMD

- Administrative convenience and productivity:
  - Efficient to respond to documentation requests electronically.
- Reduced labor costs:
  - esMD helps to reduce the amount of labor required to fulfill these requests by no longer having to print and mail paper, feed a fax machine, or burn CD's.
- Reduced hard costs:
  - esMD can also reduce hard costs like shipping and handling expenses.

Health Information Handlers (HIH)

HIHs are organizations that develop and maintain CONNECT compatible gateways to facilitate the exchange of documents between providers and RCs. A HIH acts as an agent on behalf of the provider. Examples include:

- **Health Information Exchange (HIE)/Regional Health Information Organization (RHIO).**
- **Release of Information (ROI) Vendor –** A company that manages the release of information for providers. Their services may include logging and tracking requests, retrieving patient records from multiple locations in multiple formats, identifying the information needed to fulfill requests, requesting additional authorization, if needed, packaging, and mailing.
- **Electronic Health Record (EHR) Vendor.**
- **Claim Clearinghouse.**
- **Health Internet Service Provider (HISP) –** An entity that provides services that enable providers or health organizations to exchange health information using the internet.

esMD RCs

- A/B Medicare Administrative Contractors (A/B MAC).
- DME Medicare Administrative Contractors (DME MAC).
- Comprehensive Error Rate Testing (CERT) Contractor.
- Payment Error Rate Measurement (PERM) Contractor.
- Qualified Independent Contractors (QIC).
- Quality Improvement Organizations (QIO).
- Railroad Retirement Board (RRB).
- Recovery Audit Contractors (RAC).
- Supplemental Medical Review Contractor (SMRC).
- Unified Program Integrity Contractors (UPIC).

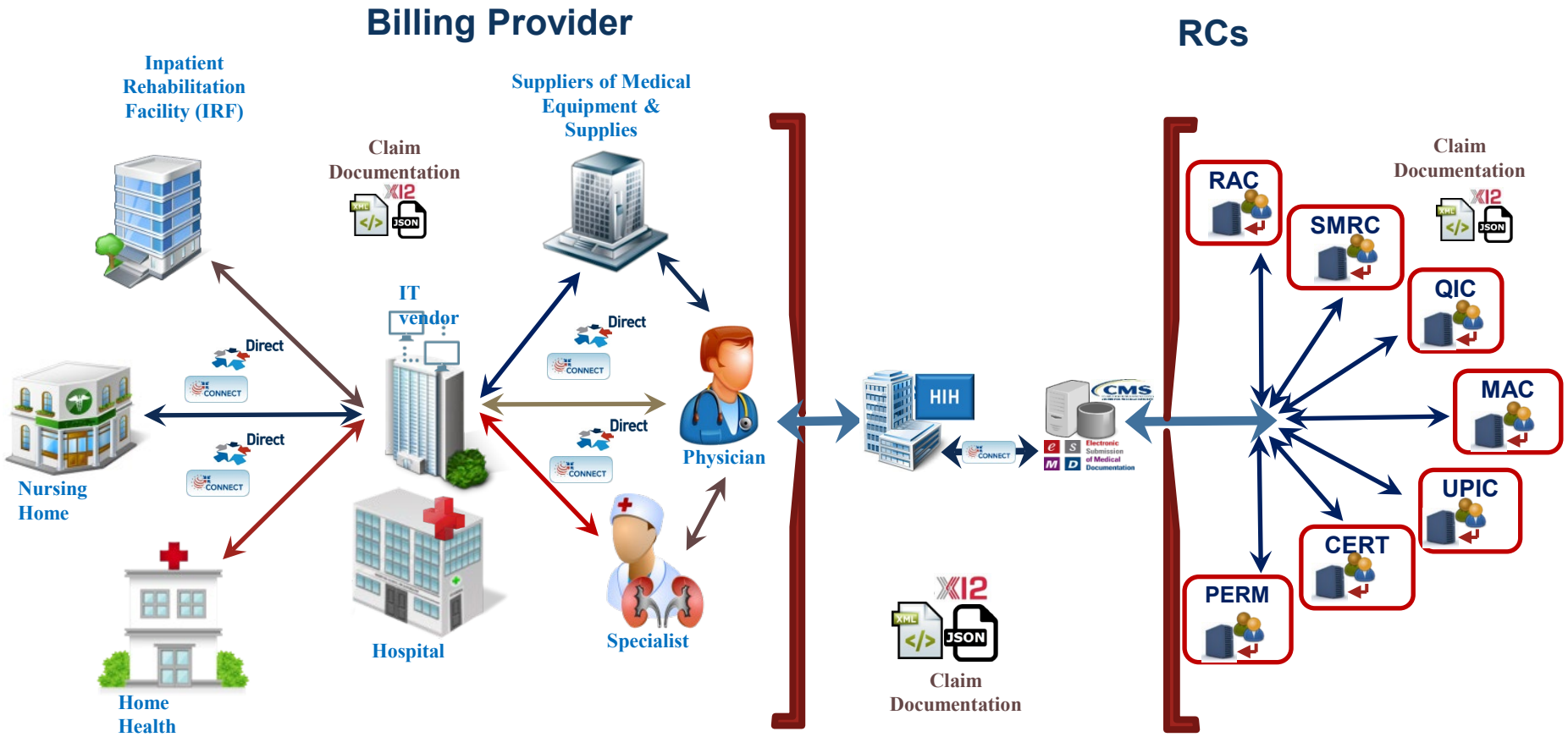
Please visit the esMD for Medicare Providers and Suppliers website for more information.

esMD Supported Lines of Business

- eMDR/ADR Responses.
- Hospital Outpatient Department (OPD) Services.
- Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT).
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).
- Review Choice Demonstration for Home Health Services.

Please send any questions you have to the esMD Business Owner mailbox via email at: **esMDBusinessOwners@cms.hhs.gov.**

esMD Process Flow



Takeaways and PERM Resources

Takeaways and PERM Resources for Providers

- Please remember the importance of timeliness on responses and submission of documents when requested.
- Follow provider submission instructions listed on the final page of the letter packet.
- Verify records submitted are complete, legible, and include all relevant documentation to support the sample claim.
- Please contact the PERM RC by phone or email with any questions or concerns regarding medical records requests.

Takeaways and PERM Resources for Providers, continued

- CMS PERM Website:
  - This website includes a page devoted to resources for providers including frequently asked questions, an example of a documentation request letter, and an explanation of what documentation you need to submit by type of service.