Florida Payment Error Rate Measurement Program

Spring 2017
Training Objectives

• Provide an overview of the Payment Error Rate Measurement Program (PERM).
• Share the findings of the Federal Fiscal Year 2014 sample.
• Prepare Florida Medicaid and CHIP Providers for the upcoming medical records requests for Federal Fiscal Year 2017.
Quiz Question #1

What does PERM stand for?
Answer

Payment Error Rate Measurement
Section 1

Introduction
The Improper Payments Information Act (IPIA) of 2002 (HR 4878) requires federal government agencies to estimate their improper payments annually and 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 actions the agency is taking to reduce the improper payments.
The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments.
Centers for Medicare and Medicaid Services & PERM

As a result, the Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with the IPIA and related guidance issued by OMB.

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program.
The error rates are based on reviews of:

- fee-for-service
- managed care, and
- eligibility components of Medicaid and CHIP in the fiscal year under review.

It is important to note the error rate is not a “fraud rate” but a measurement of payments made that did not meet statutory, regulatory or administrative requirements.
Quiz Question #2

The Improper Payments Information Act (IPIA) of 2002 (HR 4878) requires federal government agencies to estimate their improper payments annually and identify those that may be susceptible to:

a. significant improper payments
b. estimate the amount of improper payments
c. submit those estimates to Congress
d. submit a report on actions the agency is taking to reduce the improper payments.
e. All of the above
Section 2
Selected Medical Review Findings 2014
PERM Review
No custodian of records on file for Medicaid providers who closed their business
Closing Business

• The provider must notify the Medicaid fiscal agent if it is closing its business.

• The notification must include the provider’s Medicaid ID and the effective date of the business closure.
Providers failed to notify Medicaid of changes of address
Change of Address

• The following four addresses may be housed on the provider file:
  – service address
  – pay-to address
  – mail-to or correspondence address
  – home or corporate office address.
To ensure accurate communication, including prompt payment for services rendered, providers must report address changes.

If first class mail to a provider’s service address is returned, Medicaid will suspend claim payments to the provider or the provider’s group for services rendered by that provider.

After 90 days, the suspended claims will be denied if the provider has not taken corrective action.
To report a change of address, the provider must obtain and complete the Medicaid provider change of address request from the secure area of the Web Portal; or by calling the Medicaid fiscal agent’s Provider Services Contact Center at 1-800-289-7799 and selecting Option 4.
No Medicaid record retention for the required time
The provider must retain all records related to services rendered to Florida Medicaid recipients for a period of at least five years from the date of service.
Types of Records that Must be Retained

Medicaid requires that the following types of records, as appropriate for the type of service provided, must be retained (the list is not all inclusive):

- Medicaid claim forms and any documents that are attached.
- Professional records, such as appointment books, activity logs, patient treatment plans, physician progress notes, orders, and referrals.
- Medical, dental, optometric, hearing, hospital, and other patient records.
Types of Records that Must be Retained, cont’d

• Copies of sterilization and hysterectomy consents.
• Prior and post authorization, and service authorization information.
• Prescription records.
•Orders for laboratory tests and test results.
• X-ray, MRI, and CAT scan records.
• Business records, such as accounting ledgers, financial statements, invoices, inventory records, check registers, cancelled checks, sales records, etc.
Types of Records that Must be Retained, cont’d

- Tax records, including purchase documentation.
- Drug utilization reports by drug NDC.
- Partnership records.
- Patient counseling documentation.
- Provider enrollment documentation.
- Utilization review and continued stay approvals for psychiatric or substance abuse inpatient stays.
Insufficient or illegible recipient medical records submitted by provider
Record Keeping Requirement

• Records can be kept on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law or Medicaid requirements.

• In order to qualify as a basis for reimbursement, the records must be signed and dated within two business days from the date and time of service, or otherwise authenticate the record by signature, written initials, or computer entry. Electronic signatures are permissible as defined in Chapter 668, Part I, F.S.

• Rubber stamped signatures must be initialed.
Record Keeping Requirement

The records must be:
- Accessible
- Legible
- Comprehensible
Electronic Records

• Medicaid providers who maintain electronic records are required to implement a mechanism by which electronic records can be produced in a paper format within a reasonable time, upon request by the Agency.
Medicaid Provider Agreement

Provider Responsibilities

• Retain all medical and Medicaid-related records for a period of at least five years to satisfy all necessary inquiries by the Agency.
ss. 409.907 & 409.913, F.S.

• In accordance with ss. 409.907 and 409.913, F.S., authorized state and federal agencies and their authorized representatives may audit or examine a provider or facility’s Medicaid-related records.

• This examination includes:
  – all records that the Agency finds necessary to determine whether Medicaid payment amounts were or are due and applies to the provider’s records
  – records for which the provider is the custodian
ss. 409.907 & 409.913, F.S., cont’d

- The provider must give authorized state and federal agencies and their representatives access to all Medicaid patient records and documentation.

- The provider must send, at his expense, legible copies of all Medicaid-related information to the authorized state and federal agencies and their authorized representatives upon request.
Right to Review Records

• At the time of the request, all records must be provided regardless of the media format in which the original records are retained by the provider.

• All medical records must be reproduced as paper copies unless otherwise authorized by the requestor.
Requirements for Medical Records

Medical records must state the necessity for and the extent of services provided. The following requirements may vary according to the service rendered:

- Description of what was done during the visit
- History
- Physical assessment
Requirements for Medical Records, cont’d

- Chief complaint on each visit
- Diagnostic tests and results
- Diagnosis
- Treatment plan, including prescriptions
- Medications, supplies, scheduling frequency for follow-up or other services
Requirements for Medical Records, cont’d

- Progress reports, treatment rendered
- The author of each (medical record) entry must be identified and must authenticate his entry by signature, written initials or computer entry
- Dates of service
- Referrals to other services.

*Providers need to refer to the service-specific Coverage and Limitations Handbook for record keeping requirements that are specific to a particular service.*
Incomplete Records

• Providers who are not in compliance with the Medicaid documentation and record retention policies described in this chapter may be subject to administrative sanctions and recoupment of Medicaid payments.

• Medicaid payments for services that lack required documentation or appropriate signatures will be recouped.
Quiz Question #3

How long must the provider retain all records related to services rendered to Florida Medicaid recipients?
Providers must retain records for a period of at least five years from the date of service.
Claims not billed in accordance with policy stated in the Florida Medicaid handbooks.
Florida Medicaid Handbooks

• The Florida Medicaid program develops the Medicaid handbooks to supply Medicaid providers with policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.

• The handbooks provide detailed descriptions and instructions about how and when to complete forms, letters, or other documentation.
Types of Handbooks

There are three types of Florida Medicaid handbooks:

1. Provider General Handbook
2. Coverage and Limitations Handbooks
3. Reimbursement Handbooks
The *Florida Medicaid Provider General Handbook* applies to all Medicaid providers and offers information regarding:

- The Florida Medicaid program
- Recipient eligibility
- Provider enrollment
- Fraud and abuse policy, and
- Resources
The Coverage and Limitations Handbooks explains covered services and policies for each type of Medicaid Service.
Reimbursement Handbooks

• Each reimbursement handbook is named for the claim form that describes and explains how to complete and file claims for reimbursement from Medicaid.

• The reimbursement handbooks also contain eligibility information, general Medicaid information, and claim instructions.
The current Medicaid Provider Fee Schedules include the covered services codes and maximum fees for covered services.

The Medicaid Provider Fee Schedules are provided in PDF and Microsoft Excel format.
Provider Fee Schedules, cont’d

• Procedures that are not listed on the provider’s Medicaid fee schedule (procedure code table) are non-covered services.

• Florida Medicaid Fee Schedules are available for download on the Agency’s web site at http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml.
Reminder

Florida Medicaid providers must follow Medicaid policy in all three types of handbooks:

- Florida Provider General Handbook
- Florida Medicaid Provider Reimbursement Handbook
- Service specific Coverage and Limitations Handbook
Quiz Question #4

What are the 3 types of Medicaid Handbooks?
There are three types of Florida Medicaid handbooks:

Provider General Handbook
Coverage and Limitations Handbooks
Reimbursement Handbooks
Section 3
2017 Florida PERM
2017 Florida PERM

• In Florida, for FFY 2017, CMS will measure for both the Medicaid and Children’s Health Insurance Program (CHIP):
  – Medicaid fee-for-service claim payments.
  – Managed care capitation and premium payments made on behalf of beneficiaries.
  – Measurement to estimate the level of error in its eligibility determinations (Please note: For this cycle Florida continues its 5th Round of the CMS Eligibility Pilot. An Eligibility error rate will not be calculated for this cycle. Florida’s Medicaid and CHIP eligibility error rate from FFY2011 will be carried over to calculate an overall state specific error rate.)
• CMS will use two national contractors to measure improper payments in Medicaid and CHIP.

• The first contractor, The Lewin Group, will provide statistical support to the program by selecting a sample of claims to be reviewed and then calculating Florida’s error rate.
The second contractor, *CNI Advantage, LLC*, will provide documentation/database support by collecting medical policies from the state and medical records from the providers.

This contractor will also conduct medical and data processing reviews of the sample claims.
What should you do if your claims are selected to be in the sample review?
2014 Florida PERM, cont’d

• If a claim for a service that you rendered to either a Medicaid or CHIP recipient is selected to be in the sample, *CNI Advantage, LLC* will contact you for a copy of your medical records to support the medical review of that claim.
• Medical records will be needed for these reviews to determine if fee-for-service Medicaid and CHIP claims were correctly paid.

• From the date of contact, you must submit these medical records within 75 calendar days.
Consequences of Non-Response

• If you do not submit the requested supporting medical documentation, the claim will be coded as an error and any monies paid will be recouped.

• Since dollars estimated as being paid in error from the sample will be projected to the total claims, the actual impact of each claim error will be magnified several times.

• This will result in an exponentially negative impact on the Florida Medicaid program.

• If the error rate is excessive, the Agency may have to add controls or other limitations to address problem areas that are identified.
Tips for a Successful Review

- Comply with any medical records request from the CMS contractor.

- Check Medicaid provider alerts and bulletins for upcoming PERM information and Provider PERM trainings offered by the CMS.

- If your office is selected for medical records review, you will need to provide those as requested by CNI Advantage, LLC.
Bill in accordance with the billing procedures outlined in the Provider General Handbook and within the program policy handbook for the specific procedure code, units, and level of care are being billed or reversed on a claim.

Make sure when billing to double check recipient account information.
Reminders

If you have changed your address or telephone number and have not updated your information with the Agency, this is a good opportunity to do so, as you are required to report any changes per the Provider General Handbook.

Providers must promptly notify Medicaid of any change of address by obtaining and completing the Medicaid provider change of address request from the secure area of the Web Portal; or by calling the Medicaid fiscal agent’s Provider Services Contact Center at 1-800-289-7799 and selecting Option 4.
Reminder: Custodian of Records

• If closing out a former custodian, list the individual’s name and the date they departed.

• If adding a new custodian, list the individual’s:
  – name
  – home address
  – date of birth
  – Social Security Number
  – whether they are the financial or medical custodian, and
  – the date they started.
Reminder:
Custodian of Records

• Background screening is required.

• Please view the Background Screening page under Enrollment on the Medicaid Public Web Portal for more information. Please visit the website: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/index.shtml
This slide is a representation of what you’ll see when you visit the Background Screening page.

Background Screening

The Background Screening Unit processes screening results for health care providers in Florida currently licensed by the Agency for Health Care Administration. Processing includes making a determination of eligibility and evaluating applications for exemption. The Unit is also responsible for the maintenance and administration of the Care Provider Background Screening Clearinghouse.

Click logo for access to the Clearinghouse Website.

Taylor Haddock, Unit Manager
Background Screening
Bureau of Central Services

✉ BGScreen@ahca.myflorida.com
Telephone: (850) 412-4503
Notification to DCF Regarding Change in Resident Medicaid Eligibility

- Medicaid nursing home providers must notify DCF within 10 days of any changes which may affect a resident’s eligibility.

- Some examples of factors affecting eligibility include:
  - discharge from the facility
  - temporary absence from the facility, and
  - the death of the resident.
Notification to DCF Regarding Change in Resident Medicaid Eligibility

• Changes may be submitted via My ACCESS Account, faxing the Client Discharge and Change Notice, (CF- ES 2506 Form) to 1-866-658-4135, or by phone to the Customer Call Center, 1-866-762-2237.

• A copy of this form may be obtained by going to: http://www.dcf.state.fl.us/dcfforms/Search/DCFFormSearch.aspx. Enter CF-ES 2506 under “Form Number,” then click “Search.”
Scenarios to Avoid

- Not submitting medical records in the time frame specified by the PERM review contractor.
- Insufficient documentation provided to PERM review contractor.
- Not following Medicaid billing policy.
Resources
All Florida Medicaid handbooks, fee schedules, forms, provider notices, and other important Medicaid information are available on the Agency’s website.

http://ahca.myflorida.com/medicaid/review/index.shtml
CMS PERM Website

• The following slide is a representation of what you will see when you visit the CMS Payment Error Rate Measurement (PERM) website at:
Payment Error Rate Measurement (PERM)

The Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA) requires the heads of Federal agencies to annually review programs they administer and identify those that may be susceptible to significant improper payments, to estimate the amount of improper payments, to submit those estimates to Congress, and to submit a report on actions the agency is taking to reduce the improper payments. The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. As a result, CMS developed the Payment Error Rate Measurement (PERM) program to comply with the IPIA and related guidance issued by OMB.

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review. It is important to note the error rate is not a “fraud rate” but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements. FY 2008 was the first year in which CMS reported error rates for each component of the PERM program.

Downloads

PERM Overview [PDF, 382KB]
Become familiar with the Agency for Health Care Administration's PERM Website at: http://ahca.myflorida.com/Medicaid/perm/

**Florida Payment Error Rate Measurement (PERM)**

Florida is one of 17 States in a three-year cycle randomly selected by the Centers for Medicare and Medicaid Services (CMS) for the Payment Error Rate Measurement (PERM) Initiative for Federal fiscal year (FFY) 2017 (October 1, 2016 – September 30, 2017). This will be Florida’s fourth time participating in the PERM Initiative. (The three previous cycle measurements were in FFY 2008, FFY 2011, and FFY 2014.) For FFY 2017, CMS will measure Medicaid fee-for-service (FFS) claim payments, managed care capitation and premium payments made on behalf of beneficiaries. CMS PERM will also continue to conduct its fifth round of the 50-state Medicaid and Children’s Health Insurance Program (CHIP) Eligibility Review Pilot targeted measurements. (Previous Rounds of the Pilot targeted measurements occurring between FFY 2014-2016).

PERM is designed to comply with the Improper Payments Information Act of 2002 (IP_IA; Public Law 107-300).

**CMS PERM Information**

- Provider Alerts
- Provider Bulletins
- Provider Education

**Florida PERM Contact Information**
Additional Resource

If you have questions, please contact:
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