

Florida Payment Error Rate Measurement Program



Spring 2017



FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for All Floridians
AHCA.MyFlorida.com

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

Improper Payments Information Act



- 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.

Office of Management & Budget

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.

Centers for Medicare and Medicaid Services & PERM

- 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.

Change of Address, cont'd

- 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.

Change of Address, cont'd

- 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

Record Retention

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?

Answer

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.

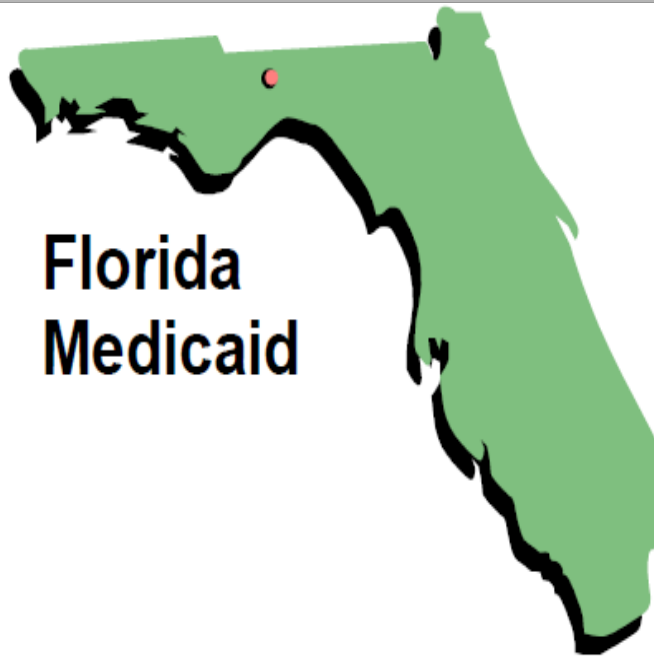
Florida Medicaid Handbooks

- 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



Florida Medicaid

PROVIDER GENERAL HANDBOOK

Agency for Health Care Administration
July 2012



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

Coverage and Limitations Handbooks

The Coverage and Limitations Handbooks explains covered services and policies for each type of Medicaid Service.

The screenshot shows the website header with the logo and name 'AGENCY FOR HEALTH CARE ADMINISTRATION' on the left, a search bar on the right, and a navigation menu with links: HOME, ABOUT US, MEDICAID, LICENSURE & REGULATION, FIND A FACILITY, and REPORT FRAUD. The main content area is titled 'Rules' and contains the following text: 'The Rules Unit is responsible for coordinating and providing support to Florida Medicaid staff related to administrative rules promulgated in the Florida Administrative Code. Below you can access rule information about adopted rules and rules currently in the promulgation process including, any incorporated reference material such as coverage policies (formally handbooks), fee schedules, forms and drafts.' Below this text are three sections: 'Rules in Progress' with one bullet point about draft rule reference materials; 'Adopted Rules' with five bullet points: 'General Policies', 'Service-Specific Policies', 'Other Policies', 'Reimbursement Policies and Fee Schedules', and 'Fee Schedules and Billing Codes'; and 'Florida Medicaid Forms'.

Rules

The Rules Unit is responsible for coordinating and providing support to Florida Medicaid staff related to administrative rules promulgated in the Florida Administrative Code.

Below you can access rule information about adopted rules and rules currently in the promulgation process including, any incorporated reference material such as coverage policies (formally handbooks), fee schedules, forms and drafts.

Rules in Progress

- Draft Florida Medicaid rule reference materials, if available, for the public to access during the rule promulgation process. These documents are not final until they are adopted into rule. Agendas for the public meetings/workshops/hearings are available on this page.

Adopted Rules

- **General Policies** - Rules that are universally applicable to the Florida Medicaid program.
- **Service-Specific Policies** - Rules for individual Florida Medicaid covered services and waiver programs.
- **Other Policies** - Rules pertaining to other aspects of the Florida Medicaid program.
- **Reimbursement Policies and Fee Schedules** - Rules pertaining to submitting claims for reimbursement and reimbursement methodologies.
- **Fee Schedules and Billing Codes** - Florida Medicaid fee schedules and billing codes
- **Florida Medicaid Forms** - Forms pertaining to the Florida Medicaid program.

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.

Provider Fee Schedules

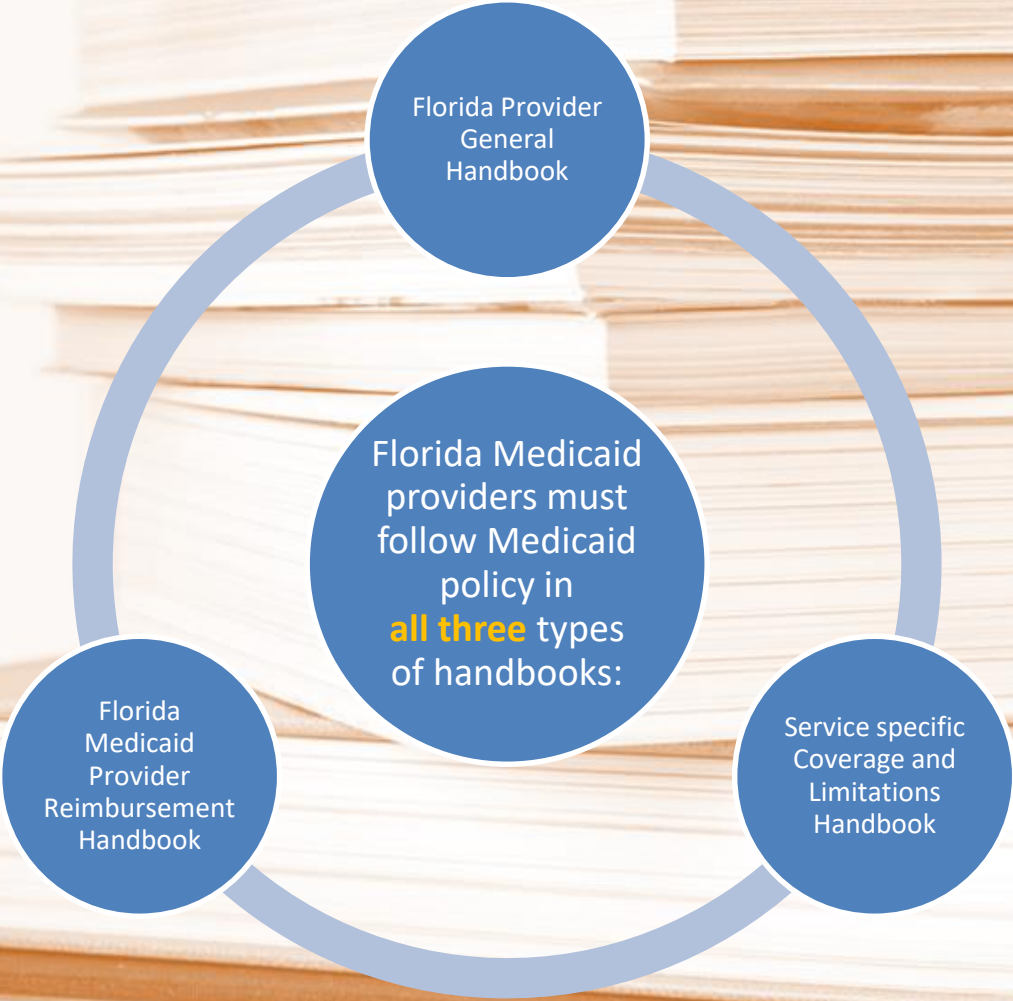
- The current Medicaid Provider Fee Schedules include the covered services codes and maximum fees for covered services.
- The Medicaid Provider Fee Schedules are provided in PDF and Microsoft Excel format.

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 Provider
General
Handbook

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

Florida
Medicaid
Provider
Reimbursement
Handbook

Service specific
Coverage and
Limitations
Handbook

Quiz Question #4

What are the 3 types of Medicaid Handbooks?

Answer

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.

2017 Florida PERM, cont'd

- 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.

2017 Florida PERM, cont'd

- 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.

2017 Florida PERM, cont'd

- 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*.

Reminder

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:

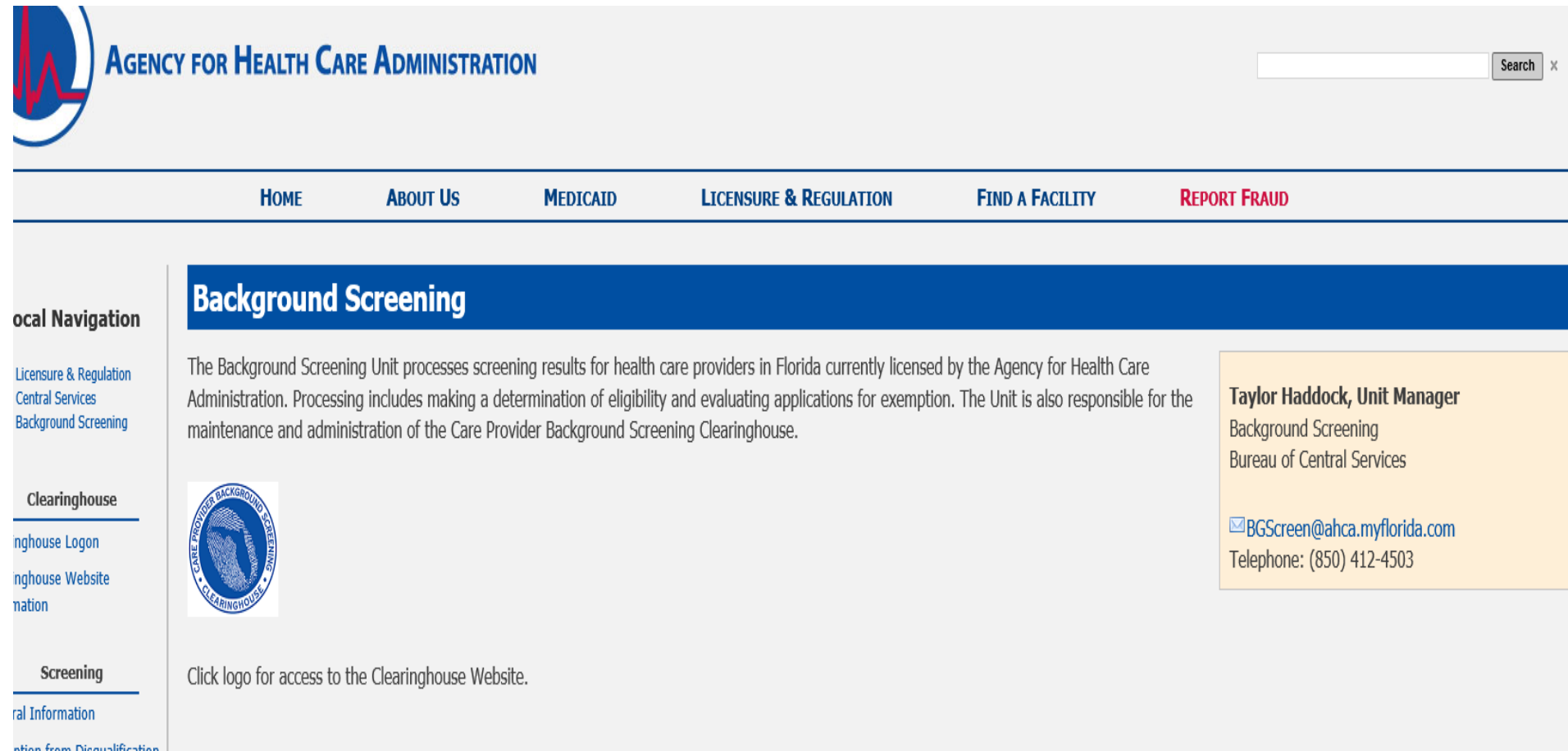
Custodian of Records

- 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.



The screenshot shows the top of the AHCA website. The header includes the AHCA logo and name, a search bar, and a navigation menu with links for HOME, ABOUT US, MEDICAID, LICENSURE & REGULATION, FIND A FACILITY, and REPORT FRAUD. The main content area features a blue banner for 'Background Screening' with a descriptive paragraph. To the left is a 'Local Navigation' sidebar with links for 'Clearinghouse' and 'Screening'. To the right is a yellow box with contact information for Taylor Haddock, Unit Manager. A circular logo for the 'Care Provider Background Screening Clearinghouse' is also present.

AGENCY FOR HEALTH CARE ADMINISTRATION

HOME ABOUT US MEDICAID LICENSURE & REGULATION FIND A FACILITY REPORT FRAUD

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.

Clearinghouse

Clearinghouse Logon
Clearinghouse Website
Registration

Screening

Registration Information
Registration from Disqualification

Taylor Haddock, Unit Manager
Background Screening
Bureau of Central Services
✉ BGSscreen@ahca.myflorida.com
Telephone: (850) 412-4503

Click logo for access to the Clearinghouse Website.

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



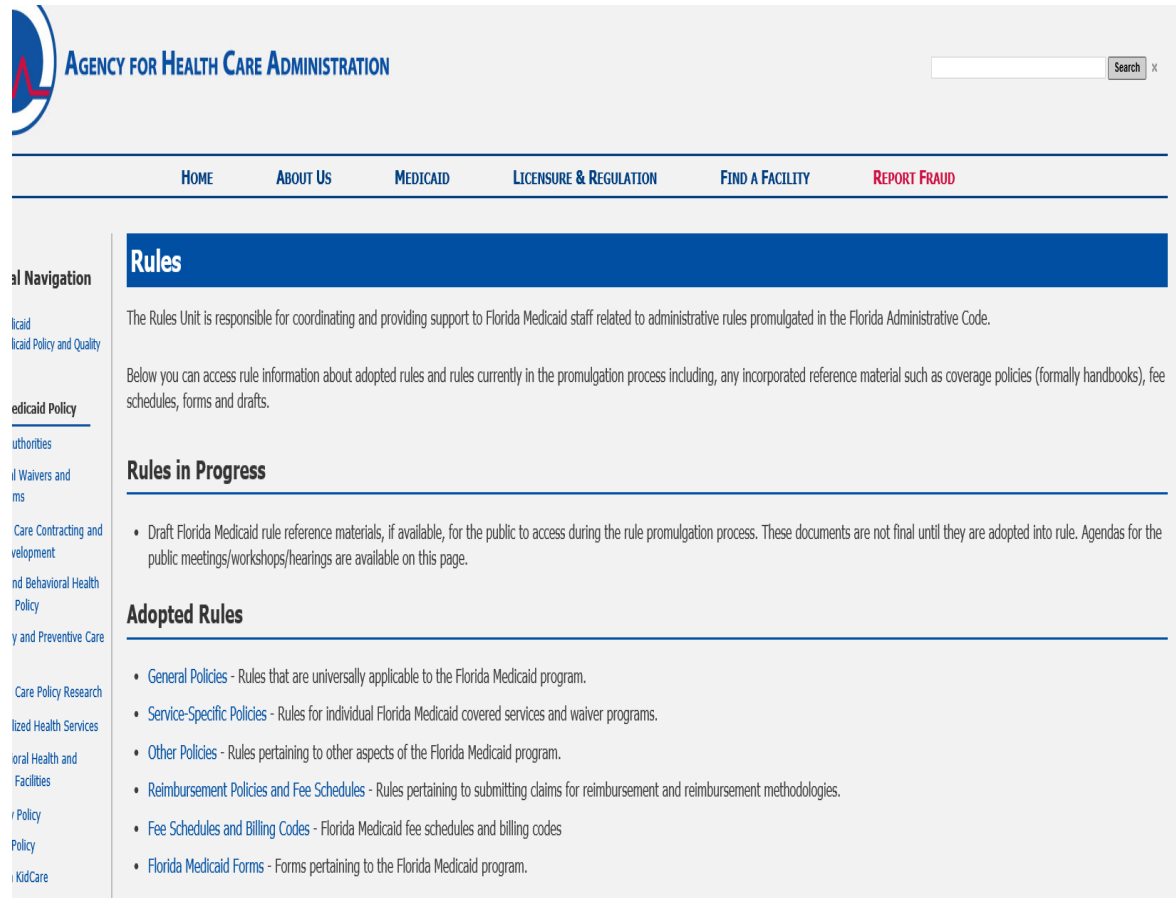
- Not submitting medical records in the time frame specified by the PERM review contractor.
- Insufficient documentation provided to PERM review contractor.
- Not following Medicaid billing policy.

Resources



<http://ahca.myflorida.com/medicaid/review/index.shtml>

All [Florida Medicaid handbooks](#), fee schedules, forms, provider notices, and other important Medicaid information are available on the Agency's website.



The screenshot shows the AHCA website's Medicaid Rules page. At the top, the AHCA logo and name are visible, along with a search bar. A navigation menu includes links for HOME, ABOUT US, MEDICAID, LICENSURE & REGULATION, FIND A FACILITY, and REPORT FRAUD. The main content area is titled "Rules" and contains the following text:

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- **Florida Medicaid Forms** - Forms pertaining to the Florida Medicaid program.

A left-hand navigation menu lists various categories: Medicaid Policy, Waivers and Appeals, Care Contracting and Development, and Behavioral Health Policy, among others.

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:
<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/index.html>

Medicare

Medicaid/CHIP

Medicare-Medicaid
Coordination

Private
Insurance

Innovation
Center

Regulations
and Guidance

Research, Statistics,
Data and Systems

Outreach and
Education

Home > Research, Statistics, Data and Systems > [Payment Error Rate Measurement \(PERM\)](#) > [Payment Error Rate Measurement \(PERM\)](#)

Payment Error Rate Measurement (PERM)

[Laws and Regulations](#)

[PERM Error Rate Findings and
Reports](#)

[Cycle 1](#)

[Cycle 2](#)

[Cycle 3](#)

[Corrective Action Plan \(CAP\)](#)

[Process](#)

[Providers](#)

[PERM Workgroups](#)

[FY2014-FY2016 Medicaid and CHIP](#)

[Eligibility Review Pilots](#)

[PERM Contacts](#)

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 Web site at: <http://ahca.myflorida.com/Medicaid/perm/>



Local Navigation

Medicaid
Medicaid Policy and Quality

Medicaid Quality

Performance Evaluation and
Arch

Quality Review and
ives

Performance Review
Clinical Monitoring

Case Management
acts

Medicaid Policy

Local Authorities

General Waivers and
Programs

Managed Care Contracting and
Development

Physical and Behavioral Health
Age Policy

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 (IPIA; Public Law 107-300).

CMS PERM Information

Provider Alerts

Provider Bulletins

Provider Education

Questions and Answers

Florida PERM Contact Information



Additional Resource

If you have questions, please contact:

Jason Ottinger, MPA

Government Analyst II

Utilization Management Contracts Unit

Division of Medicaid

Telephone: 850-412-4695

email: Jason.Ottinger@ahca.myflorida.com

