IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201767 OCTOBER 10, 2017

Payment Error Rate Measurement Audits

The federal fiscal year (FFY) 2017 Centers for Medicare & Medicaid Services (CMS) Payment Error Rate Measurement (PERM) audit of the Indiana Medicaid program has begun. The *Improper Payments Information Act of 2002* (IPIA) requires providers to submit selected medical record documentation to federal contractors during the FFY PERM audit cycle. The IPIA directs federal agencies, in accordance with the Office of Management and Budget (OMB) guidance, to review their programs to determine those that are susceptible to significant erroneous payments and to report the improper payment estimates to Congress. The OMB identified Medicaid and the State Children's Health Insurance Program (SCHIP) as programs at risk for significant erroneous payments.

The CMS developed the Medicaid and SCHIP PERM audit to measure the accuracy of member enrollment and provider payments. States are reviewed on a rotating three-year schedule. The current FFY 2017 review involves Medicaid services rendered from October 1, 2016, through September 30, 2017. The Medicaid and SCHIP programs are reviewed separately in three areas:

- Fee-for-service claims
- Managed care claims
- Program eligibility

PERM review responsibilities

Two federal contractors share responsibilities to conduct a review of the Medicaid and SCHIP fee-for-service and managed care claims. Responsibilities are divided in the following manner:

- Statistical contractor (SC) – Responsible for selection of claims sample and conducting the calculation of the claim error rates; current SC contractor is The Lewin Group.
- Review contractor (RC) – Responsible for the collection of medical policies and for conducting the medical reviews and claim adjudication reviews Additional information is provided upon final selection of the contractors involved; current RC contractor is Chickasaw Nation Industries (CNI) Advantage.

Medical record collection process

The RC conducts reviews of selected Medicaid and SCHIP claims to determine if the claims were paid correctly. When a claim is selected in the sample for a service rendered to a Medicaid or SCHIP recipient, the RC contacts the provider directly for a copy of the provider's medical records to support the medical review of the claim. To facilitate this process, it is important that the provider enrollment information on file with the Indiana Health Coverage Programs (IHCP) be current. Providers can view and update their enrollment information using the Provider Maintenance link in the IHCP Provider Healthcare Portal at indianamedicaid.com. The RC asks providers whether they prefer to receive

the request for medical records by facsimile or U.S. mail. After receiving a request for medical records, ***the provider must submit the information electronically or via hard copy within 75 days***. The RC or State staff follows up with the provider at regular intervals to ensure that the requested information is submitted on time. Providers do not receive reimbursement for responding to a PERM request for medical records.

Past studies have shown that the principal cause of errors during the medical review is insufficient or no documentation submitted for review. A lack of documentation is an easily preventable error. Accordingly, the Indiana Family and Social Services Administration (FSSA) requests that providers submit complete information before the 75-day deadline. Any documentation requested from providers that is not received timely by the RC for review is considered an error against a State's Medicaid or SCHIP program. The timeline provided will not be extended, and this error cannot be disputed with the RC. ***If federal financial participation (FFP) is disallowed for a claim, or a portion of the claim, that amount is recouped from the provider***.

Protected health information concerns

Providers should submit documentation using the methods described by the RC. Understandably, providers are concerned with maintaining the privacy of patient information. Remember that providers are required by Section 1902 (a) (27) of the *Social Security Act* to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish the CMS with information, including medical records, regarding any payments claimed by the provider for rendering services. In addition, the collection and review of protected health information (PHI) contained in individual-level medical records for payment review purposes is permissible by the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) and implementing regulations at *45 Code of Federal Regulations, parts 160 and 164*.

Contact information

Communication with the RC and the State FSSA PERM contacts is encouraged. The RC communicates contact information directly to providers. Contact information for FSSA PERM audit staff is as follows:

MS58
FSSA Office of Medicaid Policy and Planning
SUR PERM communication
402 West Washington Street, Room E442
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