OVERVIEW OF DP REVIEW PROCESS

PERM RC FAST FACTS

OVERVIEW

The PERM Review Contractor (RC), Empower AI, conducts Data Processing (DP) reviews on each sampled Medicaid (Title XIX) and CHIP (Title XXI) Fee-For-Service (FFS) claim, fixed or aggregate payment, and managed care payment to determine if a claim adjudicated correctly. The DP reviewers use state systems data and supporting documentation, federal regulations, state laws, state policies, or other contractual or legal documents used to process the claim to make the review determination.

The state's claim payment information source may include the state Medicaid Management Information System (MMIS) or another system of record (e.g., third party vendor for pharmacy, dental, or behavioral health care; sister agency waiver or non-waiver payments; stand-alone CHIP payment system; or state agency vendor payment system).

To conduct the DP review, reviewers will need access to additional information from the state's provider enrollment, claim imaging, and prior authorization systems. If the reviewers cannot view any required information using direct system access, the state will need to supply the information to the RC DP review team using an alternate method, e.g., screen prints. The DP reviewers use the information to validate specific review data elements listed in the tables below for FFS, managed care, and fixed payments.

ELEMENTS VALIDATED

DP reviewers validate detailed information for the following review elements:

- Beneficiary Information.
- Third Party Liability (TPL).
- Provider Information.
- Completion of Risk-Based Screening (RBS) of Enrolled Providers.
- Accurate Claim Payment.
- Accurate Managed Care Capitation Payment.

States must identify and provide DP reviewers with access to needed systems of record for the following:

- Provider enrollment.
- Payment for services including waiver services.

- Payments on financial transactions including capitation payments, health insurance premiums, payments to sister agencies.

PAYMENT TYPES SUBJECT TO DP REVIEW

The table below shows the payment types that are included in DP reviews along with the overall validation for each including requirements for moderate- and high- risk provider and supplier types.

Payment Type	Validation Process Overview
Fee-for-Service	Examine line items or headers in each claim to validate the state processed the claim correctly.
Managed Care Organization (MCO) Capitation	Determine if the state accurately processed the capitation payment or premium payment.
Limited Benefit Plans, Non-risk Plans; Fixed Fee or Capitation	Verify the correct payment for programs such as Primary Care Case Management (PCCM), disease management, and Non-Emergency Medical Transportation (NEMT).
Health Insurance Premium Payment (HIPP) Programs	Validate the amount paid to individuals or health plans is accurate.
Reinsurance or Stop Loss Payments to MCOs	Validate the amount paid is accurate.
Drug Administration Capitation Payments to Nursing Facilities	Validate the amount paid is accurate.
Medicare Premium Payments	Validate the amount paid is accurate.
Aggregate Payments	Validate the payment accuracy for services paid in aggregate for a group of beneficiaries.

The tables below show the specific review data elements validated by DP reviewers for FFS, managed care, and fixed payments.

FEE-FOR-SERVICE PAYMENTS – SUMMARY OF REVIEW ELEMENTS VALIDATED
BENEFICIARY
• Beneficiary ID. • Date of death. • Date of birth/age. • County of residence. • City/ZIP code. • Gender. • Citizenship status. • Living arrangements. • Patient liability/level of care. • Managed care/health plan enrollment. • Medicare and/or other insurance coverage (e.g., TPL). • Medicaid is considered the payer of last resort.

FEE-FOR-SERVICE PAYMENTS – SUMMARY OF REVIEW ELEMENTS VALIDATED
• Aid category/program eligibility and effective dates (relative to sampled dates of service) are verified through direct access to eligibility source system. States supply an eligibility extract, or the PERM Eligibility Review Contractor (ERC) provides screen prints if the state is unable to supply an extract.
PROVIDER(S) REQUIRING ENROLLMENT
• Provider name. • Provider National Provider Identifier (NPI) (HIPAA 5010 adherence). • Registration/enrollment. • Provider license or certification including Clinical Laboratory Improvement Amendments (CLIA), if applicable. • Provider Type/specialty. • Provider and service location. • Provider sanctions/suspension periods. • Office of Inspector General/List of Excluded Individuals and Entities (OIG/LEIE) verification check conducted independently. • Provider enrollment revalidation. Compliance with provider enrollment/RBS requirements under 42 CFR 455 Subpart E as applicable and appropriate for risk level assignment: • OIG/LEIE. • National Plan and Provider Enumeration System (NPPES). • Social Security Administration's Death Master File (SSA DMF). • System for Award Management/Excluded Parties List System (SAM/EPLS). • Site Visit (moderate- and high-risk individual and organizational providers). • Fingerprint-Based Criminal Background Check (FCBC) (high-risk individual providers).
CLAIM PAYMENT
• Verify timely filing requirements. • Verify service coverage determination. • Verify use of ICD-10 codes for claims with date of service on or after 10/01/2015. • Review prior authorization requirements and verify prior authorizations issued. • Identify duplicate payments and adjustments made within 30 days prior to and 60 days after the PERM sampled payment. • Review reference screens with service parameters, effective dates, and rates for National Drug Codes (NDC), procedure codes, revenue code, Diagnosis Related Group (DRG), per diem, provider contract, procedure codes, Relative Value Unit (RVU), etc. • Determine accurate payment calculation by re-pricing each sampled payment manually to determine if the payment was made in accordance with published state policies and rates in effect for the dates of service under review.

State PERM samples may include capitated payments of monthly premiums for health care, behavioral health, mental health, and dental services. DP reviewers will validate most of the beneficiary information identified under the FFS review elements in the table above and will additionally perform a review of the elements in the following table.

MANAGED CARE PAYMENTS SUMMARY OF REVIEW ELEMENTS VALIDATED
MANAGED CARE SAMPLE CONTRACT(S)
• Population exclusions. • Service carve-outs. • Geographical service areas (counties, ZIP code, regions, and/or applicable maps). • Managed care/health plan enrollment policy regarding prorated payments.
HEALTH PLAN AND CAPITATION PAYMENT
• Medicaid/CHIP provider enrollment applicable to capitation month. • Capitation rates, including an audit trail to the rate paid if not viewable in the payment system. • Capitation payment history screens. • Capitation rate cells (demographics). • Identify duplicates and record adjustments made within 30 days prior to and 60 days after the PERM sampled payment.

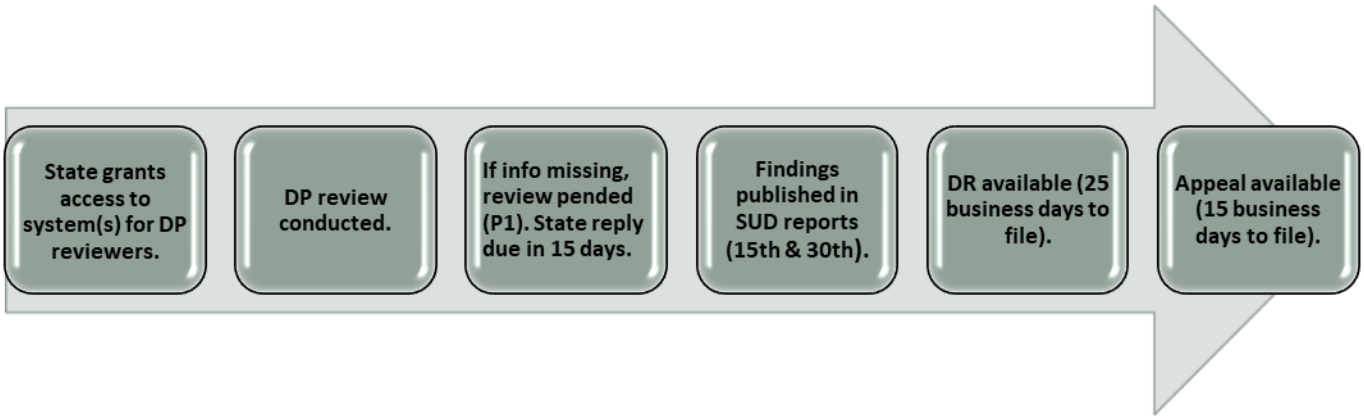
Fixed payments in the state's PERM sample may include payments made on behalf of an eligible beneficiary for the following: NEMT, HIPP, Medicare Part A and B monthly buy-in premium, PCCM or disease management, or another state-specific aggregate payment. Depending on the payment selected, DP reviewers may need to access information regarding fixed and aggregate payments as noted in the following table.

FIXED AND AGGREGATE PAYMENTS – SUMMARY OF REVIEW ELEMENTS VALIDATED
• Beneficiary program eligibility and enrollment in the applicable program. • Ability to view the payment details on, for example, claims, invoices, Medicare buy-in (BENDEX) payments. • Verification of the rate paid based on rate schedule, contract, or federal/state policy. • Identify duplicates and record adjustments made within 30 days prior to and 60 days after the PERM sampled payment. • Provider enrollment detail and RBS if applicable. • A copy of the vendor contract with the state.

DP PROCESS FLOW

The graphic below shows the basic process flow of the DP reviews. State responsibilities during the process include promptly identifying all state systems that contain the information needed by DP reviewers, providing access to the various systems, monitoring the DP Pending P1 list and submitting requested information promptly, and reviewing the review findings on the SUD report. States may submit a Difference Resolution (DR) request if the state disagrees with review findings. The state must submit the DR request within 25 business days of publication on the SUD report. The RC will review the additional information submitted with the DR request and render a decision. State DP contacts will receive

a PERM alert email with the DR decision. A state may file an Appeal request for CMS review if the state disagrees with the DR decision. The state must submit the Appeal request within 15 business days of the DR decision. Be sure to include any additional information and supporting documentation with the appeal request and provide a brief summary and factual bases to support the appeal. The RC communicates the Appeal decision to the state DP contacts via a PERM alert email.



ADDITIONAL SUPPORT

The RC designates a Regional Coordinator for each state to facilitate communications between the state and the RC. A state may submit questions to the RC via email using the following email addresses:

- RY23 Cycle 2 States: Use email PERMRC_2023@empower.ai.
- RY24 Cycle 3 States: Use email PERMRC_2024@empower.ai.
- RY22 Cycle 1 States: Use email PERMRC_2022@empower.ai.

Additional Fast Facts sheets are available with more details on the steps in the above process including the following:

- DP Pending P1 List.
- Accessing the SUD Report in SMERF.
- Filing a Difference Resolution.
- Filing an Appeal.
- Duplicate Payment Checks.
- Medicare Premium Buy-in Payments.
- Validating Beneficiary Information.
- Validating Risk-Based Screening Documentation.
- State Responsibilities for DP Reviews.
- RC Secure File Transfer via Kiteworks.