OVERVIEW OF MEDICAL REVIEW (MR) PROCESS

PERM RC FAST FACTS

OVERVIEW

The PERM Review Contractor (RC), Empower AI, conducts a comprehensive MR on each sampled Medicaid and Children's Health Insurance Program (CHIP) Fee-For-Service (FFS) claim. The PERM RC medical reviewer evaluates each claim based on medical record documentation, federal and state/district/territory[1] regulations, policies, and guidelines related to the claim. The MR determines the appropriateness of the service provided and whether the documentation supports the claim. The RC reviews the provider's medical record and/or other supporting documentation supporting the service(s) claimed to determine whether the service meets all of the following criteria:

- The service was medically necessary.
- The service was reasonable.
- The service was provided in the appropriate setting.
- The service was billed correctly.
- The service was coded accurately.
- The service was paid correctly in accordance with federal and state regulations, policies, and guidelines.
- The service was covered by Medicaid or CHIP, as applicable.

The RC conducts MRs on all sampled FFS claims with the exception of Part A and Part B premiums, Primary Care Case Management (PCCM) payments, aggregate payments, other PERM fixed payments, denied claims, and zero-paid claims. MRs may be required for denied claims if the state denied the claims for medical necessity or other reasons verifiable only through MRs.

Since the RC reviews the providers' medical records and/or other documentation supporting the service(s) claimed, *C1 Correctly Paid* findings often depend on obtaining records necessary for MRs. Therefore, medical records requests (MRR) are an important piece of the PERM RC's MR process. The RC's Customer Service Representative (CSR) team, MRR team, MR team, and states work closely together to ensure the MR team has all the records needed to complete MRs. When the RC receives medical records and/or other supporting documentation, the RC determines whether the submitted documentation is appropriate and sufficient to complete the MRs by evaluating if:

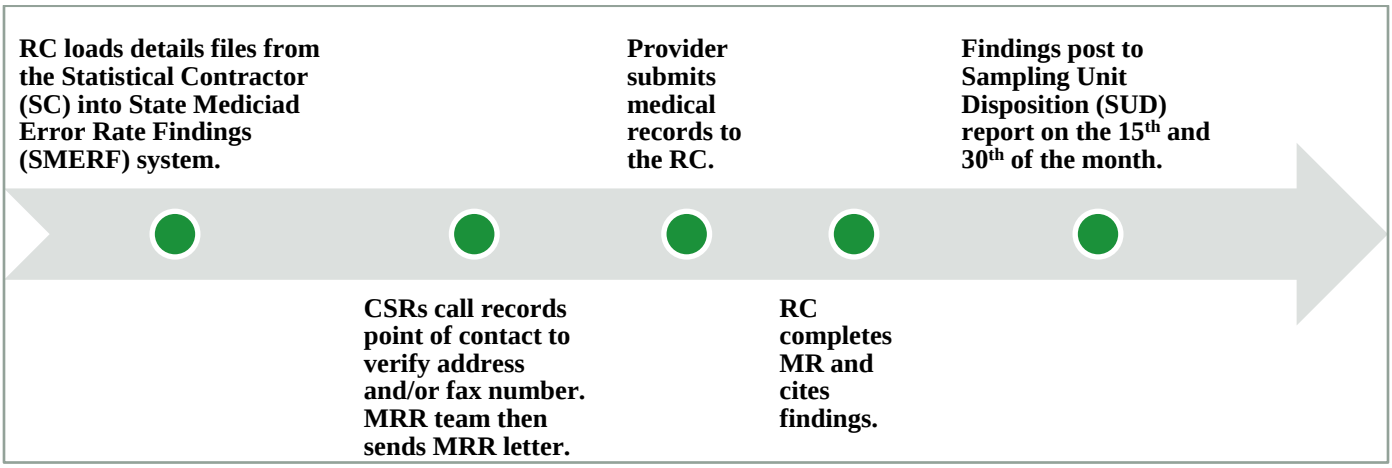
- The documentation received supports the service(s) billed.
- The documentation supports the requested sampling unit under review.

[1] Hereinafter, collectively referred to as "state."

- The documentation supports the date(s) of service.
- The documentation includes signed orders.
- The documentation includes approved certifications/re-certifications required by state policy.

For state best practices to support MRRs, refer to the PERM RC Fast Facts flyer *State Responsibilities Medical Reviews*.

See the following general MRR/MR process flow graphic:



POLICY COLLECTION

During the pre-cycle phase of the cycle before reviews begin, the RC performs policy collection to obtain federal and state regulations, policies, and guidelines applicable during the review cycle. The RC compiles the state's regulations, policies, and guidelines in order to create a state-specific *Master Policy List* (MPL) and works with each individual state to create a final MPL each cycle by following these steps:

1) The RC obtains publicly available federal and state regulations, policies, and guidelines through ongoing individual research throughout the cycle.
2) The RC gathers information from state responses provided in the SC's *State Information Survey* (completed by the state in May of the first year of the cycle) and the RC's *MRR/MR Policy Questionnaire* (completed by the state in October/November of the first year of the cycle).
3) Using information obtained in the above steps, the RC creates a draft MPL during December of the first year of the cycle. In January of the second year of the cycle, the RC sends the draft MPL to each state for review and confirmation that the MPL is complete and accurate.
4) Each state adds, deletes, and corrects regulation/policy/guideline information within the draft MPL during the state review.
5) Once the state approves the MPL, the RC finalizes the MPL and provides a copy to the state.
6) The RC then uploads federal and state regulations, policies, and guidelines into SMERF for the MR team to reference while completing the MR portion of the PERM audit.

MR PROCESS

The MR reviewer compares the information presented on the claim with all of the following:

- Providers' medical record and/or other documentation supporting the service(s) claimed.
- Federal and state regulations, policies, and guidelines that are applicable.

The RC completes the MR on each sampling unit within twenty calendar days after the receipt of the complete medical records for the associated unit. The MR ensures the sampling unit was properly paid, reduced, or denied, which may require a cross check between data processing (DP) and MR. In most cases, PERM will only sample individual line items. In order to determine the accuracy of the individual line sampled, the RC may sometimes need to review all items on a claim. However, the RC will only cite errors for the individual line sampled by the SC.

The table below shows the MR review steps and the considerations made by the MR reviewer at each step in the review.

MR Review Steps	MR Reviewer Considerations
The RC medical reviewer (nurse and certified coder) will determine whether the RC received sufficient documentation for MR.	Did the RC receive all information necessary to support the services of the claim? The original MRR lists the specific medical records and/or supporting documents that providers are asked to submit for each claim category. If sufficient documentation is not submitted, the RC will send an additional documentation request (ADR) to the provider for the missing documentation prior to citing all MR2, MR3, MR4, MR5, MR7, MR8, and MR10 error findings. Click the link for the MR finding codes.
Determine whether the service was provided in accordance with federal and state policy.	Is the procedure documented within the medical record a covered service under federal and state regulations, policies, and guidelines? Are there any service limitations applicable to the covered service (e.g., units, quantities)? Were the services provided within those limitations?
Confirm the medical necessity of the service.	Were the services provided consistent with the symptoms and/or diagnosis under treatment? Does the documentation support the patient's condition and the provider's treatment of the patient's condition?
Determine whether the service provided matches the service codes the provider billed and the payer paid.	Are the procedures and corresponding diagnoses relevant to the billed procedure code? Did the provider bill the correct code for the service?
Verify appropriate physician certification.	If required by state policy, is there a signed physician certification for long-term care, inpatient hospital services, and/or home health?

MR Review Steps	MR Reviewer Considerations
Enter claim review determination.	Is the payment correct? Is there an error? Reviewers record results in SMERF.

The graphic below shows the basic process flow of the state interactions with MRs. State responsibilities during the process include submitting records promptly to the RC (if providers submit records to the state contacts), reviewing the MR findings on the SUD report, and requesting repricing of partial errors.

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 determine whether the finding can be overturned, modified, or is upheld. State MR contacts will receive a PERM alert email with the DR decision.

A state may file an Appeal request for CMS review if the DR result is upheld or modified and 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 basis to support the appeal. If the state provides new documentation in support of the appeal, the RC first reviews the submitted documentation to determine if it warrants a change to the contractor's DR decision without sending the Appeal request to CMS. If the documentation is not new or the RC cannot overturn or modify the decision based on the submitted documentation, the RC notifies CMS of the pending appeal. CMS then reviews all documentation including documentation related to the initial review and the DR and issues an Appeal decision of overturned, modified, or upheld. The RC communicates the Appeal decision to the state MR contacts via a PERM alert email.

The RC will determine the initial dollar value of the error as 100% of the paid amount. For partial errors, states may utilize the DR process to request repricing or request repricing via email to the RC after the DR timeframe closes until the end of the cycle.

MR FINDING CODES

The table below shows the MR finding codes. A finding of C1 means that the medical reviewer found no payment error in the claim, i.e., the review result was a correct finding. A Medical Technical Deficiency (MTD) is a finding that did not result in a payment error. An MTD may occur when the National Drug Code (NDC) is different on the claim than in the record, but it does not affect payment. An MTD may occur when the procedure or diagnosis code is incorrect, but it does not affect payment.

Code	Definition	Code	Definition
C1	**Correctly Paid**	**MR6**	**Number of Unit(s) Error**
MR1	**No Documentation Error**	**MR7**	**Medically Unnecessary Service Error**
MR2	**Document(s) Absent from Record Error**	**MR8**	**Policy Violation Error**
MR3	**Procedure Coding Error**	**MR9**	**Improperly Completed Documentation**
MR4	**Diagnosis Coding Error**	**MR10**	**Administrative/Other Error**
MR5	**Unbundling Error**	**MTD**	**Medical Technical Deficiency**

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.
- RY25 Cycle 1 States: Use email PERMRC_2025@empower.ai.

Providers may submit questions about MRRs and supporting documentation to the RC via email using the email address PERMRC_ProviderInquiries@empower.ai. States and/or providers submitting questions by email should include only the PERM ID as the reference/identifier and should not include any personally identifiable information (PII) and protected health information (PHI).

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

- *State Responsibilities for MR.*
- *Repricing MR Partial Errors.*
- *Accessing the SUD Report in SMERF.*
- *Filing a DR.*
- *Filing an Appeal.*
- *RC Secure File Transfer via Kiteworks.*