

Payment Error Rate Measurement (PERM) 2016

Frequently Asked Questions about the PERM Program

What is PERM?

The Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, enacted on November 26, 2002, requires the heads of Federal agencies to review annually programs they oversee that are susceptible to significant erroneous payments, to estimate the amount of improper payments, to report those estimates to the Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures. The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and the State Children's Health Insurance Program (CHIP) and produces state and national-level error rates for each program. The error rates are based on reviews of Medicaid and CHIP fee-for-service (FFS) and managed care payments made in the Federal fiscal year (FY) under review.

How often are states measured under PERM?

PERM uses a 17-state rotational approach to measure improper payments in Medicaid and CHIP for the 50 states and the District of Columbia over a three-year period. As a result, each state is measured once, and only once, every three years. The rotation allows states to plan for the reviews because they know in advance when they will be measured.

Vermont is currently conducting 2016 PERM cycle review of provider payments which will occur October 2015 through the Fall of 2017. The 2016 PERM cycle will review payments to providers during federal fiscal year 2016 (October 2015 - September 2016). Due to the newness of the Affordable Care Act (ACA), an eligibility review will not occur during the 2016 PERM cycle.

What does PERM Program do?

The purpose of PERM is to examine claims payment in the Medicaid program and Children's Health Insurance Program (CHIP) for accuracy and to ensure that the States only pay for appropriate claims.

How do I know if PERM Review applies to me? Payments made to all provider types will be part of the review process. Any claim that is paid by Vermont Medicaid between October 1, 2015 and September 30, 2016 will be part of the payment universe review. A sample of claims will be randomly drawn from each quarter, and these will be the claims reviewed by the federal contractor. **If a claim you submitted is selected, you will be notified.**

Who will contact me if I am selected?

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Vermont Medicaid will outreach to you by two methods;

1. PERM notice letters to all providers selected in one of the samples. The letter provides information regarding PERM expectations as well as how to reach Vermont Medicaid for assistance and/or PERM information.
2. Vermont Medicaid provider representatives outreached to all selected providers to collect their PERM point-of-contact and assist with initial guidance

Note: If you received a letter from Vermont Medicaid, stating that you were selected for the PERM Audit, and you did not receive a phone call from one of our Provider Representatives, please email the DVHA PERM Email @ VTPERM@hpe.com.

CMS Contractor will also contact selected providers;

1. Providers should receive an initial outreach (phone call) from the federal contractor **CNI Advantage LLC**, who you are required to send your medical documentation to.
2. Provider will receive an official letter from federal contractor **CNI Advantage LLC**, after their initial phone call, that will outline exactly what, when and how the required medical documents must be sent to them.

Note: If you **have not** been contacted by CNI Advantage, please email the DVHA PERM Email @ VTPERM@hpe.com.

Please note you are required to submit records are no cost to CNI Advantage, LLC. You cannot bill for cost of copying or mailing records

What do I need to provide if I am selected? CNI Advantage, LLC will tell providers what to send, where to send it and when. The documentation may include medical information, proof of medical necessity, and proof that the services were provided as ordered and billed with correct codes

What is the time frame to send in documentation? Providers have 30 days from the date of receipt of notice to submit required claims medical records and adjoining documents to CNI Advantage, LLC. Providers have 7 days from the date of receipt of notice, of request for additional information to submit additional claims documentation for inaccurate medical record and adjoining documents, to CNI Advantage, LLC.

What happens if I don't send in the documentation on time? Providers selected for the sample are required to submit all requested documentation to CNI Advantage, LLC as stated in your signed Provider Enrollment Agreement (Section 6) or, if you have recently revalidated your enrollment, your signed General Provider Agreement (Article VI, Section 1).

DVHA will enforce a 10% withholding of the remittance advise for providers that do not submit the required medical records and adjoining documents within 30 days or the additional documentation within 7 days. The withhold will continue until such time the issue is resolved.

Will you be recovering money from me if an error is found? If an overpayment is discovered, the provider must return the overpayment to the state within 60 days of identification of the overpayment. The state will pursue recovery of the improper payment from the provider. The state is required to return to CMS the federal share of any overpayment.

Who do I contact if I have further questions? Additional information is available at <http://dvha.vermont.gov/for-providers/payment-error-rate-measurement-perm/view>

You can call Provider Services Monday through Friday from 8:00am to 5:00pm. Toll-free in Vermont (800)925-1706; local and out-of-state (802) 878-7871.

Providers with questions may contact vtperm@hpe.com.