



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FY 2012 Pennsylvania Medicaid
Payment Error Rate Measurement (PERM) Cycle 1 Summary Report

December 20, 2013



Pennsylvania - PERM Findings FY 2012

Data Analysis for Medicaid Corrective Action Plan

This report provides an overview of the FY 2012 Payment Error Rate Measurement (PERM) findings at the national level and presents data analyses of payment errors found in the Pennsylvania PERM Medicaid sample, including projected dollars in error, to support the State during the corrective action process. The PERM corrective action process supports the identification and implementation of cost-effective approaches to reduce payment errors. PERM identifies and classifies types of errors but States must conduct root cause analysis to identify why the errors occur, a necessary precursor to effective corrective action. Thus, your participation is critical during the corrective action phase of the PERM cycle.

The Centers to Medicare & Medicaid (CMS) and its contractors reviewed the Medicaid claims for fee-for-service (FFS) and managed care. States reviewed eligibility cases. The first two sections of this report include the estimated national and State error rates based on the results of the reviewed samples. The remaining sections include sample payments in error along with the projected payments in error at the State level broken out by FFS, managed care, and eligibility. For FFS and managed care, we have also included analysis of the Pennsylvania Medicaid PERM review from the perspective of the Review Contractor that addresses FFS medical record and data processing errors as well as managed care data processing errors.

A. PERM National Medicaid Findings

In FY 2012 the overall national Medicaid estimated error rate is **5.7%**. All States measured had a Medicaid FFS program, and 13 had a Medicaid managed care program. The review findings include:

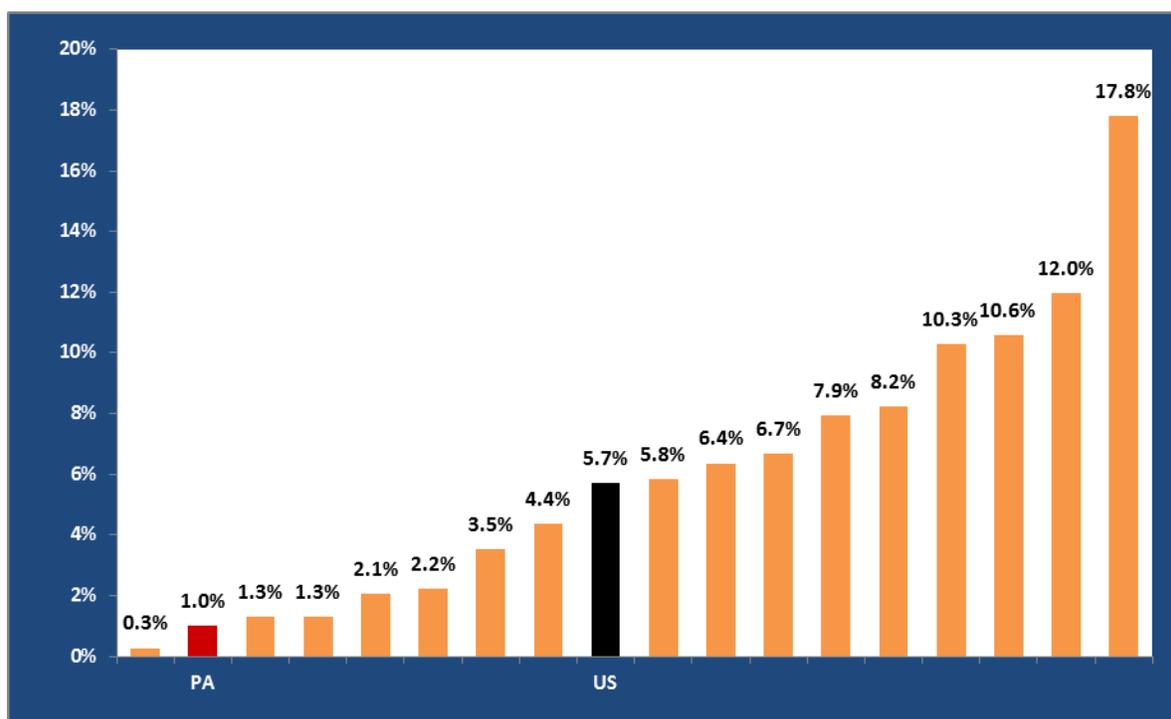
- **The national Medicaid FFS estimated error rate is 3.4%.**
 - For Medicaid FFS medical record reviews, the largest sources of projected dollars in error are due to Insufficient Documentation and Policy Violation.
 - For Medicaid FFS, projections show the most costly errors by service type are for Prescribed Drugs and Nursing Facility/Intermediate Care Facilities.
 - For Medicaid FFS data processing reviews, the largest sources of projected dollars in error are due to Non-covered Service and Pricing Error.
- **The national Medicaid managed care estimated error rate is 0.2%.**
 - The largest source of projected dollars in error is due to Non-covered Service.
- **The national Medicaid eligibility component estimated error rate is 3.3%.**
 - The largest sources of projected dollars in error are for Not Eligible and Liability Understated.

- The largest source of projected dollars in error by Eligibility Category is Aged, Blind and Disabled Categorically Needy.
- The largest source of projected dollars in error by Cause of Error is Assets: Agency Miscalculated Countable Assets.

B. Pennsylvania's Medicaid Findings

In FY 2012 Pennsylvania's Medicaid estimated error rate is **1.0%**. Figure 1 displays Pennsylvania's error rate compared to the national and other FY 2012 States' error rates.

Figure 1: State Error Rate Relative to Other States and the National Error Rate



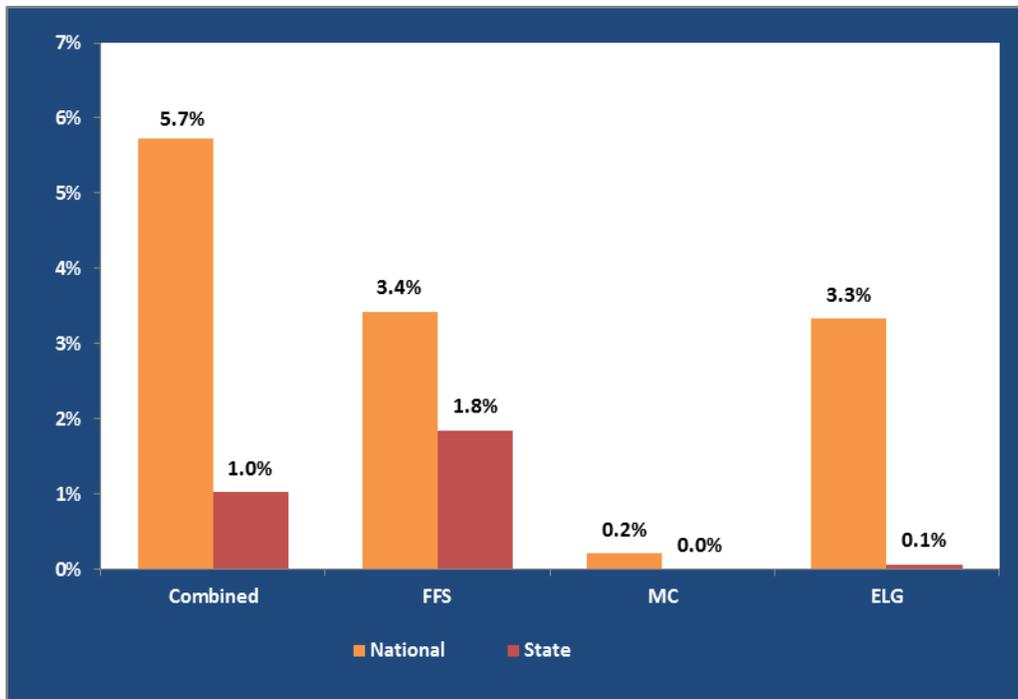
Pennsylvania's sample review findings include:

- **Pennsylvania's Medicaid FFS estimated error rate is 1.8%.**
 - For Medicaid FFS medical record reviews, the largest sources of projected dollars in error are due to Insufficient Documentation and Diagnosis Coding Error.
 - For Medicaid FFS, projections show the most costly error by service type is for Habilitation/Waiver Programs.
 - For Medicaid FFS data processing reviews, the largest sources of projected dollars in error are due to Logic Edit and FFS Claim for Managed Care Service.

- **Pennsylvania’s Medicaid managed care estimated error rate is 0.0%.**
 - For Medicaid managed care, improper payments were not identified in the sample.
- **Pennsylvania’s Medicaid eligibility component estimated error rate is 0.1%.**
 - For Medicaid eligibility, the sole source of projected dollars in error is due to Undetermined.
 - The largest source of projected dollars in error by Eligibility Category is Families with Dependent Children (General).
 - The sole source of projected dollars in error by Cause of Error is Income: Agency Miscalculated Countable Income.

Figure 2 compares the nation and Pennsylvania on the combined error rate and the component error rates.

Figure 2: National and State Combined and Component Error Rates



C. Sample Medicaid Findings and Projected Dollars in Error

The analyses in this section are for sample errors and projected dollars in error. The sample dollars in error are the improper payments found through data processing and, medical record review for the PERM claims component. Only FFS claims are eligible for medical record review. Also included in the findings are the sample dollars in error found through the state-conducted

Pennsylvania - PERM Medicaid FY2012 Findings

PERM eligibility reviews. The projected dollars in error are the claim-weighted error amounts that are used to form the numerators for each State's component error rates. The weights for each sampled claim are based on the universe size from which the sample was selected (i.e., universe of FFS claims, universe of managed care payments, universe of active eligibility cases, universe of negative eligibility cases). Table 1 summarizes the number of errors and associated dollars for Pennsylvania and nationally by component of PERM. Please note that because each of the component samples is weighted, the proportion of sample dollars in error will be different than the proportion of the projected payments in error.

Table 1: Medicaid Program Component by State and National Sample Error Payments

Medicaid Program Component	State				National			
	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error	% of Total Projected Dollars in Error	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error (\$Millions)	% of Total Projected Dollars in Error
Medicaid FFS	37	\$19,350	\$191,301,821	93.3%	283	\$157,487	\$10,359	41.6%
Medicaid Managed Care	0	\$0	\$0	0.0%	45	\$4,186	\$258	1.0%
Medicaid Eligibility	1	\$200	\$13,641,593	6.7%	412	\$153,660	\$14,278	57.4%

Table 2 compares Pennsylvania's number of errors, sample dollars in error, and projected dollars in error to those found in the 17 Cycle 1 States by error type for FFS, managed care, and eligibility.

Table 2: National and State Number of Errors and Dollars in Error by Type of Error

	Number of Errors in Sample		Sample Dollars in Error		Projected Dollars in Error	
	State	National	State	National	State	National (\$Millions)
Medical Review Errors						
Insufficient Documentation	14	79	\$3,715	\$55,027	\$87,011,000	\$3,764
Diagnosis Coding Error	6	9	\$13,273	\$29,323	\$38,053,757	\$562
Policy Violation	3	29	\$520	\$20,150	\$13,938,256	\$1,949
No Documentation	2	20	\$1,245	\$13,754	\$12,866,515	\$522
Number of Unit(s) Error	1	11	\$72	\$313	\$762,237	\$152
Admin/Other	0	12	\$0	\$1,452	\$0	\$585
Procedure Coding Error	0	5	\$0	\$342	\$0	\$156
Medically Unnecessary	0	2	\$0	\$1,211	\$0	\$5
Unbundling	0	0	\$0	\$0	\$0	\$0
Total	26	167	\$18,824	\$121,572	\$152,631,764	\$7,693
Data Processing Errors						
Logic Edit	1	3	\$25	\$105	\$32,339,264	\$158

Pennsylvania - PERM Medicaid FY2012 Findings

	Number of Errors in Sample		Sample Dollars in Error		Projected Dollars in Error	
	State	National	State	National	State	National (\$Millions)
FFS Claim for Managed Care Service	6	13	\$44	\$351	\$5,632,738	\$305
Pricing Error	4	34	\$456	\$2,158	\$698,055	\$1,131
Non-covered Service	0	69	\$0	\$40,084	\$0	\$1,562
Third-party Liability	0	4	\$0	\$580	\$0	\$103
Duplicate Item	0	3	\$0	\$39	\$0	\$55
Managed Care Payment Error	0	40	\$0	\$1,014	\$0	\$16
Admin/Other	0	0	\$0	\$0	\$0	\$0
Data Entry Error	0	0	\$0	\$0	\$0	\$0
Rate Cell Error	0	0	\$0	\$0	\$0	\$0
Total	11	166	\$525	\$44,331	\$38,670,057	\$3,331
Deficiencies						
Medical Review Deficiencies	2	18	N/A	N/A	N/A	N/A
Data Processing Deficiencies	0	11	N/A	N/A	N/A	N/A
Total	2	29	N/A	N/A	N/A	N/A
Eligibility Errors (Active Cases)						
Undetermined	1	67	\$200	\$13,482	\$13,641,593	\$1,000
Not Eligible	0	229	\$0	\$122,225	\$0	\$6,551
Liability Understated	0	68	\$0	\$11,001	\$0	\$6,503
Eligible with Ineligible Services	0	14	\$0	\$4,046	\$0	\$96
Liability Overstated	0	26	\$0	\$2,122	\$0	\$88
Managed Care Error, Ineligible for Managed Care	0	3	\$0	\$544	\$0	\$41
Managed Care Error, Eligible for Managed Care but Improperly Enrolled	0	5	\$0	\$240	\$0	\$1
Total	1	412	\$200	\$153,660	\$13,641,593	\$14,278
Eligibility Errors (Negative Cases)						
Improper Termination	0	282	N/A	N/A	N/A	N/A
Improper Denial	0	105	N/A	N/A	N/A	N/A
Total	0	387	N/A	N/A	N/A	N/A

Medicaid FFS Data Analyses

This section provides an analytical description of the reasons for Medicaid FFS payment errors. Table 3 compares Pennsylvania's FFS errors to national FFS errors by service type.

Pennsylvania - PERM Medicaid FY2012 Findings

Table 3: National and State FFS Number of Errors and Dollars in Error by Service Type

Service Type	Number of Errors in Sample		Sample Dollars in Error		Projected Dollars in Error		Error Rate	
	State	National	State	National	State (\$Millions)	National (\$Millions)	State	National
Habilitation/Waiver Programs	16	37	\$5,026	\$6,876	\$99.1	\$932.5	2.9%	2.2%
Inpatient Hospital	10	32	\$13,729	\$42,290	\$38.8	\$598.3	3.6%	1.6%
Denied Claims	1	2	\$25	\$71	\$32.3	\$149.8	N/A	N/A
Psychiatric/Mental Health/Behavioral Health Services	1	9	\$157	\$1,196	\$9.8	\$1,311.6	16.2%	8.9%
Laboratory/X-ray/Imaging Services	6	19	\$44	\$802	\$5.6	\$162.3	44.3%	13.1%
Nursing Facility/Intermediate Care Facilities	1	39	\$362	\$78,824	\$3.8	\$1,991.8	0.1%	2.4%
Prescribed Drugs	2	34	\$6	\$1,921	\$1.9	\$2,071.0	0.7%	11.3%
ICF for the Mentally Retarded/Group Homes	0	9	\$0	\$17,453	\$0.0	\$941.4	0.0%	10.3%
Outpatient Hospital Services/Clinics	0	25	\$0	\$2,932	\$0.0	\$850.1	0.0%	5.8%
Personal Support Services	0	16	\$0	\$1,289	\$0.0	\$535.3	0.0%	1.5%
Physicians/Other Licensed Practitioner Services	0	11	\$0	\$373	\$0.0	\$203.4	0.0%	2.2%
Transportation/Accommodations	0	8	\$0	\$295	\$0.0	\$133.9	0.0%	11.2%
Crossover Claims	0	9	\$0	\$222	\$0.0	\$110.4	0.0%	1.1%
Dental/Other Oral Surgery Services	0	3	\$0	\$217	\$0.0	\$102.7	0.0%	2.2%
Home Health Services	0	2	\$0	\$300	\$0.0	\$93.3	0.0%	2.2%
Capitated Care/Fixed Payments	0	20	\$0	\$2,149	\$0.0	\$67.9	0.0%	0.4%
Vision (Ophthalmology/Optomety/Optical Services)	0	2	\$0	\$70	\$0.0	\$60.0	0.0%	7.6%
Durable Medical Equipment (DME) Supplies/Prosthetic/Orthopedic Devices/Environmental Modifications	0	6	\$0	\$209	\$0.0	\$42.8	0.0%	1.6%
Hospice Services	0	0	\$0	\$0	\$0.0	\$0.0	0.0%	0.0%
Therapies/Hearing/Rehabilitation Services	0	0	\$0	\$0	\$0.0	\$0.0	0.0%	0.0%
Total	37	283	\$19,350	\$157,487	\$191.3	\$10,358.5	1.8%	3.4%

1. Medicaid FFS Medical Review – Error Type Analysis

The top reason(s) for Medicaid FFS **medical review errors** by projected dollars in error are:

- Insufficient Documentation
- Diagnosis Coding Error
- Policy Violation
- No Documentation

As shown in Figure 3, 81.9% of the projected medical review dollars in error can be attributed to Insufficient Documentation and Diagnosis Coding Error. Policy Violation, No Documentation, and Number of Unit(s) Error comprise the remaining 18.1%.

Figure 3: Medicaid FFS Medical Review Percentage of Projected Dollars in Error by Error Type

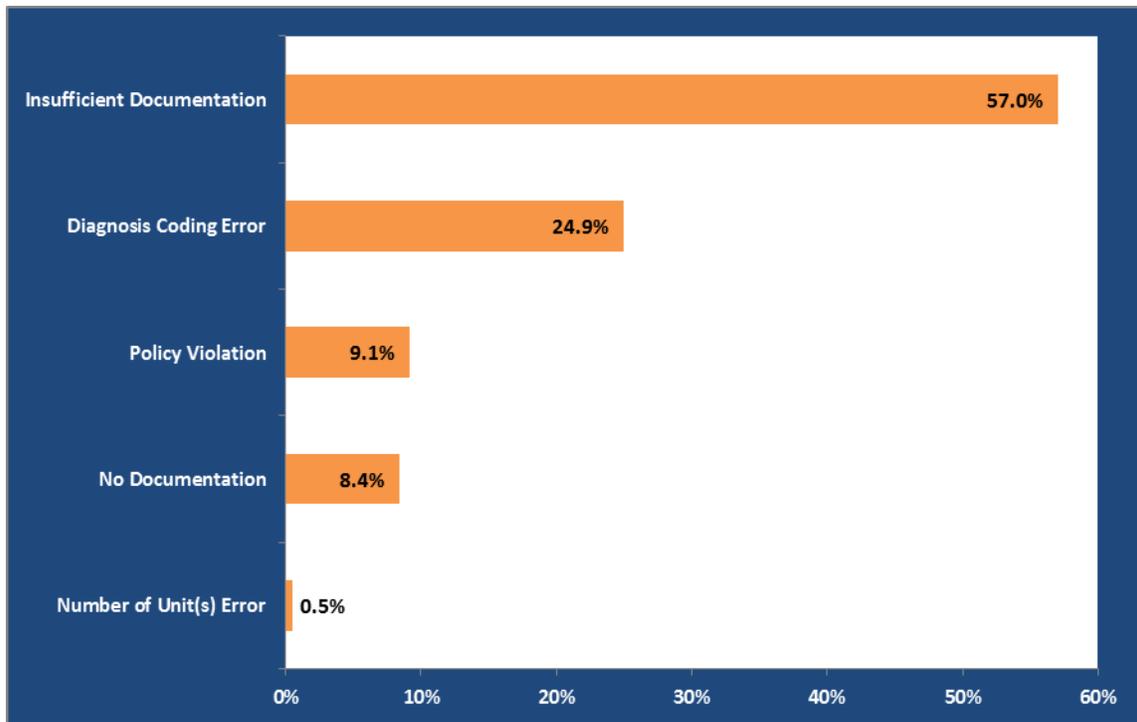


Table 4 has more information regarding the number of medical review errors and dollars in error by overpayments, underpayments, and percentage of total medical review errors.

Table 4: Medicaid FFS Medical Review Error Type by Overpayments, Underpayments, and Percentage of Medical Review Errors

Error Type	Overpayments			Underpayments			Percentage of Total Medical Review Errors		
	# of Errors	Sample Dollars in Error	Projected Dollars in Error	# of Errors	Sample Dollars in Error	Projected Dollars in Error	% of Total # of Errors	% of Total Sample Dollars in Error	% of Total Projected Dollars in Error
Insufficient Documentation	14	\$3,715	\$87,011,000	0	\$0	\$0	53.8%	19.7%	57.0%
Diagnosis Coding Error	3	\$6,447	\$21,345,689	3	\$6,826	\$16,708,067	23.1%	70.5%	24.9%
Policy Violation	3	\$520	\$13,938,256	0	\$0	\$0	11.5%	2.8%	9.1%
No Documentation	2	\$1,245	\$12,866,515	0	\$0	\$0	7.7%	6.6%	8.4%
Number of Unit(s) Error	1	\$72	\$762,237	0	\$0	\$0	3.8%	0.4%	0.5%
Total	23	\$11,999	\$135,923,697	3	\$6,826	\$16,708,067	100.0%	100.0%	100.0%

Medicaid FFS Medical Review Error Causes by Error Type

Common Causes Identified:

Insufficient Documentation

- Provider did not supply sufficient documentation to support the claim
- The medical records do not contain the Individual Service Plan
- Provider did not submit additional documentation

Diagnosis Coding Error

- According to medical record the DRG billed on claim is incorrect
- According to the medical record the diagnosis billed on the claim is incorrect

Policy Violation

- Documentation does not meet the State policy requirements for the service performed

No Documentation

- Provider did not respond to the request for records

There are five error types for medical review to report:

- 1) Fourteen (14) MR2 - Insufficient Documentation errors - The causes of these errors are as follows:

- Providers did not submit additional documentation requested for encounter progress notes, authorization for transportation, and physician orders, respectively, for three claims.
 - Quarterly service coordination documents were not submitted for the sampled dates of service.
 - Documentation was not submitted to support procedure code W1727 (Companion Services, level 3) billed for the sampled dates of service.
 - Annual re-evaluation of level of care for Home and Community-Based Services (HCBS) was not submitted for the sampled dates of service.
 - Individual Service Plan in effect for the sampled dates of service was not submitted.
 - Attendance log was not submitted to support one unit of procedure code A0434 (Specialty care transport, SCT) billed.
 - Documentation was not submitted to validate the number of units (one unit = 15 minutes) of procedure code T2025 (Waiver Services; NOS) billed for the sampled dates of service.
 - Individual Service Plan submitted was dated three years prior and not applicable to the dates of service sampled.
 - Recipient/provider timesheets were not submitted to support 196 units of procedure code W1792 (Personal Assistance Service-Consumer) for the sampled dates of service.
 - Legible documentation was not submitted to support procedure code W0020 (Special Instruction in office or home) billed for the sampled dates of service.
 - Individual Service Plan authorizing services was not submitted to support procedure code W1011 (Service Coordination) billed for the sampled dates of service.
 - Service log and/or progress notes (including start and stop times) for services rendered were not submitted to support 4 units of procedure code T1019 (Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMG, part of the individualized plan of treatment) billed for the sampled dates of service.
- 2) Six (6) MR4 - Diagnosis Coding errors - The causes of these errors are as follows:
- Principal diagnosis code 462 (Acute pharyngitis) billed was incorrect and should have been coded 403.90 (Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified) with secondary diagnosis code added for 585.90 (Chronic kidney disease, unspecified).
 - Principal diagnosis code billed 405.01 (Malignant renovascular hypertension) was incorrect and should have been coded 784.0 (Headache).
 - Secondary diagnosis code 425.4 (Other primary cardiomyopathies) was incorrect and should have been billed using code 414.8 (Other specified forms of chronic ischemic heart disease) consistent with documentation received.

- Secondary diagnosis code 427.5 (Cardiac arrest) was omitted and should have been added to the claim to be consistent with physician documentation.
 - Documentation submitted did not support a principal diagnosis of 486 (Pneumonia, organism unspecified); the principal diagnosis code should have been 410.71 (Subendocardial infarction, initial episode of care). This changed the DRG from 139 (Other Pneumonia) to 190 (Chronic Obstructive Pulmonary Disease with MCC).
 - Documentation submitted did not validate the principal diagnosis code 622.11 (Mild dysplasia of cervix) billed. The provider should have billed the principal diagnosis code 562.11 (Diverticulitis of colon, without mention of hemorrhage).
- 3) Three (3) MR8 - Policy Violation errors - The errors are as follows:
- Psychiatric diagnostic interview examination was performed, but the documentation submitted did not include start and stop times, required by State policy, to support billing for six units of procedure code 90801 (Psychiatric diagnostic evaluation) (one unit = 30 minutes) for the dates of service sampled.
 - Physician's order authorizing the recipient's leave of absence was missing for the dates of service sampled. State policy requires physician authorization to be paid for bed reservation days.
 - Prescription order was submitted for 31 units of NDC 00536329201 (Vitamin C 500mg tabs 100 each), but was not signed as required by State policy and did not cover the sampled dates of service.
- 4) Two (2) MR1 - No Documentation errors - These errors are due to the provider not submitting medical records for the sampled claims.
- 5) One (1) MR6 - Number of Units error - This error is due to the documentation submitted only supports 22 of 36 units billed for procedure code W7060 (Home and Community Habilitation - unlicensed, level 3, 15 minutes) for the date of service sampled.

1. Medicaid FFS Medical Review – Service Type Analysis

The percentages of medical review projected dollars in error by service type are displayed in Figure 4. As shown, errors found in Habilitation/Waiver Programs and Inpatient Hospital account for 89.8% of the medical review projected dollars in error. The remaining 10.2% of the projected dollars in error arise from the following services: Psychiatric/Mental Health/Behavioral Health Services; Nursing Facility/Intermediate Care Facilities; and Prescribed Drugs.

Figure 4: Medicaid FFS Medical Review Percentage of Projected Dollars in Error by Service Type

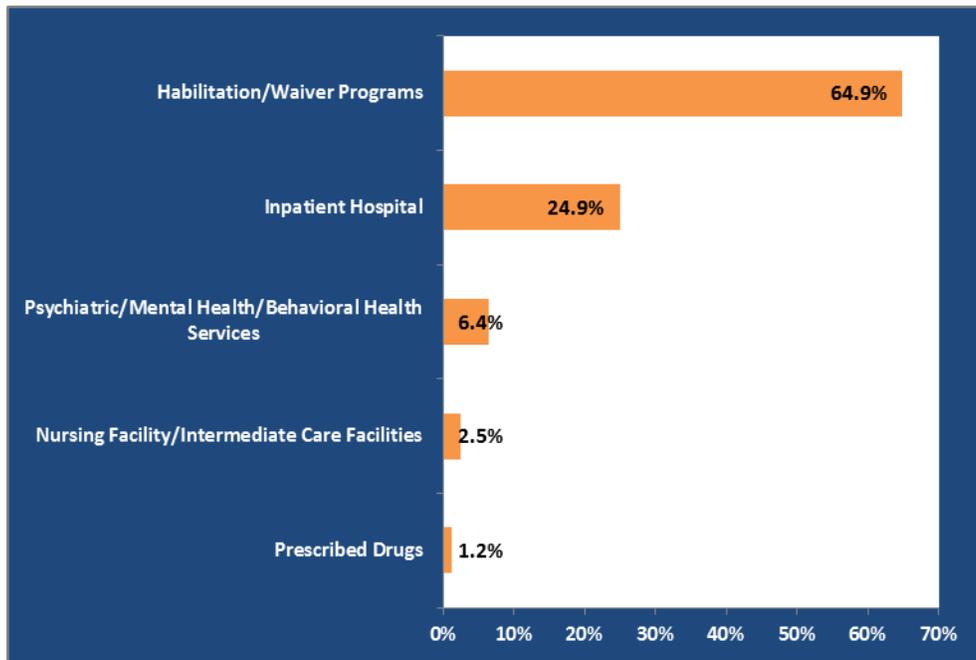


Table 5 has more information regarding the number of medical review errors and dollars in error for service types by overpayments, underpayments, and percentage of total medical review errors. The highest percentage of projected dollars in error arise from Habilitation/Waiver Programs at 64.9%, followed by Inpatient Hospital at 24.9%, Psychiatric/Mental Health/Behavioral Health Services at 6.4%, Nursing Facility/Intermediate Care Facilities at 2.5%, and Prescribed Drugs at 1.2%.

Table 5: Medicaid FFS Medical Review Errors by Service Type

Service Type	Overpayments			Underpayments			Percentage of Total Medical Review Errors		
	# of Errors	Sample Dollars in Error	Projected Dollars in Error	# of Errors	Sample Dollars in Error	Projected Dollars in Error	% of Total # of Errors	% of Total Sample Dollars in Error	% of Total Projected Dollars in Error
Habilitation/Waiver Programs	16	\$5,026	\$99,071,054	0	\$0	\$0	61.5%	26.7%	64.9%
Inpatient Hospital	3	\$6,447	\$21,345,689	3	\$6,826	\$16,708,067	23.1%	70.5%	24.9%
Psychiatric/Mental Health/Behavioral Health Services	1	\$158	\$9,780,583	0	\$0	\$0	3.8%	0.8%	6.4%
Nursing Facility/Intermediate Care Facilities	1	\$362	\$3,830,031	0	\$0	\$0	3.8%	1.9%	2.5%
Prescribed Drugs	2	\$6	\$1,896,340	0	\$0	\$0	7.7%	0.0%	1.2%
Total	23	\$11,999	\$135,923,697	3	\$6,826	\$16,708,067	100.0%	100.0%	100.0%

Pennsylvania - PERM Medicaid FY2012 Findings

As shown in Table 6, the most projected dollars in error are due to Insufficient Documentation from Habilitation/Waiver Programs, followed by Diagnosis Coding Error for Inpatient Hospital.

Table 6: Medicaid FFS Service Type by Medical Review Error Type in Projected Dollars

Service Type	Diagnosis Coding Error		Insufficient Documentation		No Documentation		Number of Units Error		Policy Violation	
	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error
Habilitation/Waiver Programs	0	\$0	13	\$85,442,302	2	\$12,866,515	1	\$762,237	0	\$0
Inpatient Hospital	6	\$38,053,757	0	\$0	0	\$0	0	\$0	0	\$0
Nursing Facility/Intermediate Care Facilities	0	\$0	0	\$0	0	\$0	0	\$0	1	\$3,830,031
Prescribed Drugs	0	\$0	1	\$1,568,698	0	\$0	0	\$0	1	\$327,642
Psychiatric/Mental Health/Behavioral Health Services	0	\$0	0	\$0	0	\$0	0	\$0	1	\$9,780,583
Total	6	\$38,053,757	14	\$87,011,000	2	\$12,866,515	1	\$762,237	3	\$13,938,256

Medicaid FFS Medical Review Error Causes by Service Type

Common Causes Identified:

Habilitation/Waiver Programs

- Insufficient Documentation
- No Documentation

Inpatient Hospital

- Diagnosis Coding Error

The specific errors identified by each service type are the following:

- 1) Day Habilitation and Waiver Programs, Adult Day Care, Foster Care, and School Based Services (16) - There are 16 errors in this service type with three error types (MR1 - No Documentation, MR2 - Insufficient Documentation, and MR6 - Number of Units error). The No Documentation errors occurred because providers did not submit the records requested for two sampled claims. The Insufficient Documentation errors occurred due to the following reasons:
 - Providers did not respond to the request for additional documentation for encounter progress notes for one claim and for authorization for transportation service for one claim.
 - Documentation was not submitted to support procedure code W1727 (Companion Services, level 3) billed for the sampled dates of service.
 - Legible documentation was not submitted to support procedure code W0020 (Special Instruction in office or home) billed for the sampled dates of service.
 - Individual Service Plans covering the dates of service billed were not submitted for two claims.
 - Individual Service Plan submitted was dated three years prior and not applicable to the dates of service sampled.
 - Recipient/provider timesheets were not submitted to support 196 units of procedure code W1792 (Personal Assistance Service-Consumer) for the sampled dates of service.
 - Documentation was not submitted to validate the number of units (one unit = 15 minutes) of procedure code T2025 (Waiver services; NOS) billed for the sampled dates of service.
 - Service log or progress notes (including start and stop times) were not submitted for services rendered to support four units of procedure code T1019 (Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMG, part of the individualized plan of treatment) billed for the sampled dates of service.
 - Quarterly service coordination documents were not submitted for one claim.

- Attendance log was not submitted to support one unit of procedure code A0434 (Specialty care transport (SCT) billed).
- Annual re-evaluation of level of care for Home and Community-Based Services (HCBS) was not submitted for the sampled dates of service.

The Number of Units error in this service category is due to the documentation submitted only supports 22 of 36 units billed for procedure code W7060 (Home and Community Habilitation -unlicensed, Level 3, 15 minutes) for the dates of service sampled.

- 2) Inpatient Hospital Services (6) - There are six errors in this service type with one error type (MR4 - Diagnosis Coding error), which resulted in incorrect payments. The causes of these errors are as follows:
- Principal diagnosis code 462 (Acute pharyngitis) billed was incorrect and should have been coded 403.90 (Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified) with secondary diagnosis code added for 585.90 (Chronic kidney disease, unspecified).
 - Principal diagnosis code billed 405.01 (Malignant renovascular hypertension) was incorrect and should have been coded 784.0 (Headache).
 - Secondary diagnosis code 425.4 (Other primary cardiomyopathies) was incorrect and should have been billed using code 414.8 (Other specified forms of chronic ischemic heart disease) consistent with documentation received.
 - Secondary diagnosis code 427.5 (Cardiac arrest) was omitted and should have been added to the claim to be consistent with physician documentation.
 - Documentation submitted did not support principal diagnosis code 486 (Pneumonia, organism unspecified); the principal diagnosis code billed should have been 410.71 (Subendocardial infarction, initial episode of care). This changed the DRG from 139 (Other Pneumonia) to 190 (Chronic Obstructive Pulmonary Disease with MCC).
 - Documentation submitted did not validate the principal diagnosis code 622.11 (Mild dysplasia of cervix) billed. The provider should have billed the principal diagnosis code 562.11 (Diverticulitis of colon, without mention of hemorrhage).
- 3) Prescribed Drugs (2) - There are two errors in this service category with two error types (MR2 - Insufficient Documentation and MR8 - Policy Violation error). The causes of these errors are the following: one Insufficient Documentation error is due to the provider not responding to the request for additional documentation of physician orders, and the one Policy Violation error is due to the prescription order was submitted for 31 units of NDC 00536329201 (Vitamin C 500mg tabs, 100 each), but was not signed as required by policies and did not cover the sampled dates of service.
- 4) Psychiatric, Mental, & Behavioral Health Services (1) - There is one MR8 (Policy Violation) error in this service type: psychiatric diagnostic interview examination was performed, but no start and stop times were documented, as required by State policy, to validate units billed for procedure code 90801 (Psychiatric diagnostic evaluation).

- 5) Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF) (1) - There is one MR8 (Policy Violation) error in this service type: the physician’s order authorizing the recipient’s leave of absence was missing for the dates of service sampled. State policy requires physician authorization to be paid for bed reservation days.

2. Medicaid FFS Data Processing Review – Error Type Analysis

The top reasons for Medicaid FFS data processing review errors in terms of projected dollars in error are Logic Edit and FFS Claim for Managed Care Service. Logic Edit accounts for 83.6%, FFS Claim for Managed Care Service accounts for 14.6%, and Pricing Error accounts for 1.8% of the total projected dollars in error.

Table 7 has more information regarding the number of FFS data processing review errors and dollars in error by overpayments, underpayments, and percentage of total FFS data processing review errors.

Table 7: Medicaid FFS Data Processing Review Error Type by Overpayments, Underpayments, and Percentage of Data Processing Errors

Error Type	Overpayments			Underpayments			Percentage of Total FFS Data Processing Review Errors		
	# of Errors	Sample Dollars in Error	Projected Dollars in Error	# of Errors	Sample Dollars in Error	Projected Dollars in Error	% of Total # of Errors	% of Total Sample Dollars in Error	% of Total Projected Dollars in Error
Logic Edit	0	\$0	\$0	1	\$25	\$32,339,264	9.1%	4.8%	83.6%
FFS Claim for Managed Care Service	6	\$44	\$5,632,738	0	\$0	\$0	54.5%	8.4%	14.6%
Pricing Error	0	\$0	\$0	4	\$456	\$698,055	36.4%	86.8%	1.8%
Total	6	\$44	\$5,632,738	5	\$481	\$33,037,319	100.0%	100.0%	100.0%

Medicaid FFS Data Processing Error Causes and Trends by Error Type

Common Causes Identified:

FFS Claim for Managed Care Service

- FFS payment should be paid under Managed Care

Pricing Error

- Co-pay should not have been deducted from payment

There are 11 data processing review errors with two trends to report:

- (1) There were six overpayment errors for total overpayments of \$44 all of which were attributable to the fact that FFS was billed and paid the claims when recipients were enrolled in managed care plans that should have covered the services. All six recipients

were enrolled in both physical and behavioral health managed care organizations on the date of service that covered laboratory services under both of the managed care organization contracts.

- (2) There were four underpayment errors (\$481 total) attributable to charging co-pays for pregnancy-related services or for emergency services which is not allowed under federal regulations. All four claims were filed by inpatient hospitals.

Additional analysis on other data processing errors by error type includes:

- One (1) additional error was cited because a legitimate physician charge related to a hospital procedure was incorrectly denied.

4. Medicaid FFS Data Processing Review – Service Type Analysis

In the following section, Medicaid FFS data processing errors are analyzed by service type. It is important to note that, since data processing errors are typically systems-based, they often are unrelated to a certain type of provider submitting claims incorrectly for a specific type of service. Therefore, the material in this section is for informational purposes only and States are cautioned against drawing conclusions about specific service types unless a clear trend was identified during data processing reviews.

As shown in Figure 5, the top service types with data processing errors are Denied Claims and Laboratory/X-ray/Imaging Services. Denied Claims accounts for 83.6%, Laboratory/X-ray/Imaging Services accounts for 14.6%, and Inpatient Hospital accounts for the remaining 1.8%.

Figure 5: Medicaid FFS Data Processing Review Percentage of Projected Dollars in Error by Service Type

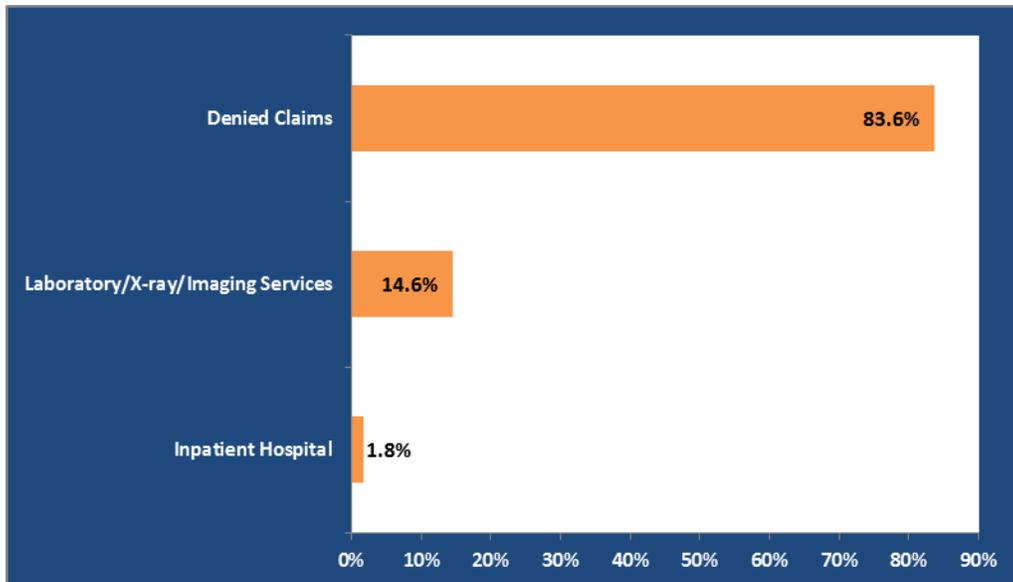


Table 8 shows that the greatest amount of projected dollars in error are due to Logic Edit from Denied Claims, followed by FFS Claim for Managed Care Service for Laboratory/X-ray/Imaging Services.

Table 8: Medicaid FFS Service Type by Data Processing Review Error Type in Projected Dollars

Service Type	FFS Claim for Managed Care Service		Logic Edit		Pricing Error	
	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error
Denied Claims	0	\$0	1	\$32,339,264	0	\$0
Inpatient Hospital	0	\$0	0	\$0	4	\$698,055
Laboratory/X-ray/Imaging Services	6	\$5,632,738	0	\$0	0	\$0
Total	6	\$5,632,738	1	\$32,339,264	4	\$698,055

Medicaid FFS Data Processing Error Causes by Service Type

Common Causes Identified:

Laboratory/X-ray/Imaging Services

- FFS Claim for Managed Care Service

Inpatient Hospital

- Pricing Error

Data processing errors are typically caused by system programming or lack of edits and a service type analysis may not be relevant as these types of errors generally may not be tied to a provider type or may not be tied to a provider billing issue. Both trends noted above were related to distinct provider types. The co-pay errors were all claims submitted by hospitals and the claims that should have been paid by a health plan were all filed by laboratories.

Medicaid Managed Care Data Analyses

There were no managed care processing review errors in Pennsylvania, therefore there are no managed care processing review analyses.

Medicaid Eligibility Data Analyses

While our eligibility data analysis is somewhat limited given that each State under the PERM program performed its own eligibility reviews, in FY 2012 CMS began collecting two additional, standardized fields to assist States in analyzing errors – Eligibility Category and Cause of Error. Below, we offer the main source(s) of eligibility errors for Pennsylvania based on the Review Finding, Eligibility Category, and Cause of Error.

Analysis by Eligibility Review Finding

Pennsylvania Medicaid had the following type of eligibility error:

- Undetermined - Undetermined means the case record lacks or contains insufficient documentation, in accordance with the State's documented policies and procedures, to make a definitive review decision for eligibility or ineligibility

Table 9 shows Pennsylvania's Medicaid eligibility review findings for active cases by error type. The largest source of projected dollars in error for active cases was Undetermined.

Table 9: Medicaid Eligibility Errors by Review Finding for Active Cases

Review Finding	# of Cases	% of Cases	Sample Dollars in Error	% of Dollars in Error	Projected Dollars in Error	% of Projected Dollars in Error
Undetermined	1	100.0%	\$200	100.0%	\$13,641,593	100.0%
Total Active Cases	1	100.0%	\$200	100.0%	\$13,641,593	100.0%

Table 10 shows the number of Medicaid eligibility errors for active cases, comparing the number of errors and projected dollars in error by case action, which is the action that is reviewed for each sampled eligibility case. An application is defined as a case that is being reviewed for the first time to determine eligibility based on a new application. A redetermination is defined as a case that is currently eligible and is either (1) due for a predetermined re-review (i.e., at 3, 6, 9 or 12 months) or (2) had a change in circumstances requiring the State to review the eligibility of the case. The projected dollars in error arise from the Application case action.

Table 10: Medicaid Eligibility Errors for Active Cases by Case Action by Number of Errors and Projected Dollars in Error

Case Action	# of Errors	% of Errors	Sample Dollars in Error	% of Dollars in Error	Projected Dollars in Error	% of Projected Dollars in Error
Application	1	100.0%	\$200	100.0%	\$13,641,593	100.0%
Total Active Cases	1	100.0%	\$200	100.0%	\$13,641,593	100.0%

For the negative case review, no errors were found in the sample.

Analysis by Eligibility Category

The projected dollars in error by eligibility category is due to Families with Dependent Children (General).

Table 11 shows Pennsylvania’s Medicaid eligibility review findings for active cases by eligibility category.

Table 11: Medicaid Eligibility Errors by Eligibility Category for Active Cases

Eligibility Category	# of Cases	% of Cases	Sample Dollars in Error	% of Dollars in Error	Projected Dollars in Error	% of Projected Dollars in Error
Families with Dependent Children (General)	1	100.0%	\$200	100.0%	\$13,641,593	100.0%
Total Active Cases	1	100.0%	\$200	100.0%	\$13,641,593	100.0%

Analysis by Eligibility Cause of Error

The projected dollars in error by cause of error is due to Income: Agency Miscalculated Countable Income.

Table 12 shows Pennsylvania’s Medicaid eligibility review findings for active cases by cause of error.

Table 12: Medicaid Eligibility Errors by Cause of Error for Active Cases

Cause of Error	# of Cases	% of Cases	Sample Dollars in Error	% of Dollars in Error	Projected Dollars in Error	% of Projected Dollars in Error
Income: Agency Miscalculated Countable Income	1	100.0%	\$200	100.0%	\$13,641,593	100.0%
Total Active Cases	1	100.0%	\$200	100.0%	\$13,641,593	100.0%

For the negative case review, no errors were found in the sample. Therefore there is no cause of error analyses.

D. Deficiencies

Deficiencies are identified when there is a discrepancy found in either the review of the claim or review of the medical record, but the discrepancy does not result in a payment error.

Table 13 lists the data processing deficiencies found in Pennsylvania as well as the medical review deficiencies.

Table 13: Medicaid Deficiencies Noted During PERM Claims Review

Review Type	# of Deficiencies	% of Deficiencies
Data Processing Deficiencies	0	0.0%
Medical Review Deficiencies	2	100.0%
Total Deficiencies	2	100.0%

The reasons for these findings are noted below.

Medical Review Deficiencies

- Procedure code is incorrect but does not affect payment

Medical Review Deficiencies

There are two medical review deficiencies to report. These deficiencies are cited due to providers' billing with incorrect codes, but it did not affect payment. One deficiency is an incorrect diagnosis code of 649.01 (Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition) that should have been billed to 654.21 (Previous cesarean delivery, delivered, with or without mention of antepartum condition), but would not have changed the DRG paid. The second deficiency is cited because the provider billed two units of procedure code S9123 (Nursing care, in the home; by registered nurse, per hour), but the documentation supported two units of procedure code S9124 (Nursing care, in the home, by licensed practical nurse, per hour). The payment on this claim was not affected since both procedure codes paid the same.

E. Types of Payment Errors

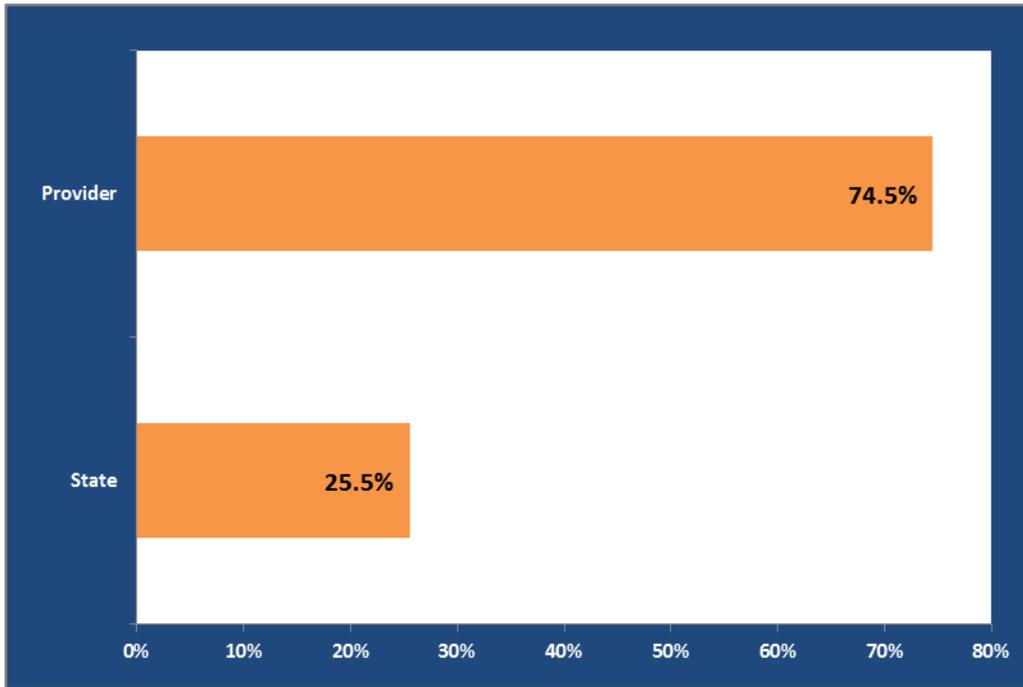
The PERM Final Rule allows for classifying data processing errors and eligibility review errors as State errors and medical review errors as provider errors. This section analyzes Pennsylvania payment errors for FY 2012 in light of this classification. Table 14 shows how the errors aggregate into these two types of payment errors.

Table 14: Medicaid Types of Payment Errors

Error Type	State or Provider Error	# of Errors	% of Total # of Errors	Sample Amount in Error	% of Sample Dollars in Error	Projected Dollars in Error	% of Projected Dollars in Error
Medical Review Errors	Provider	26	68.4%	\$18,824	96.3%	\$152,631,764	74.5%
Data Processing Errors	State	11	28.9%	\$525	2.7%	\$38,670,057	18.9%
Eligibility Errors	State	1	2.6%	\$200	1.0%	\$13,641,593	6.7%

Figure 6 shows the percentage of State versus provider errors by projected dollars in error. In Pennsylvania, State errors account for 26% of projected dollars in error, while provider errors comprise 74%.

Figure 6: Medicaid Types of Payment Errors



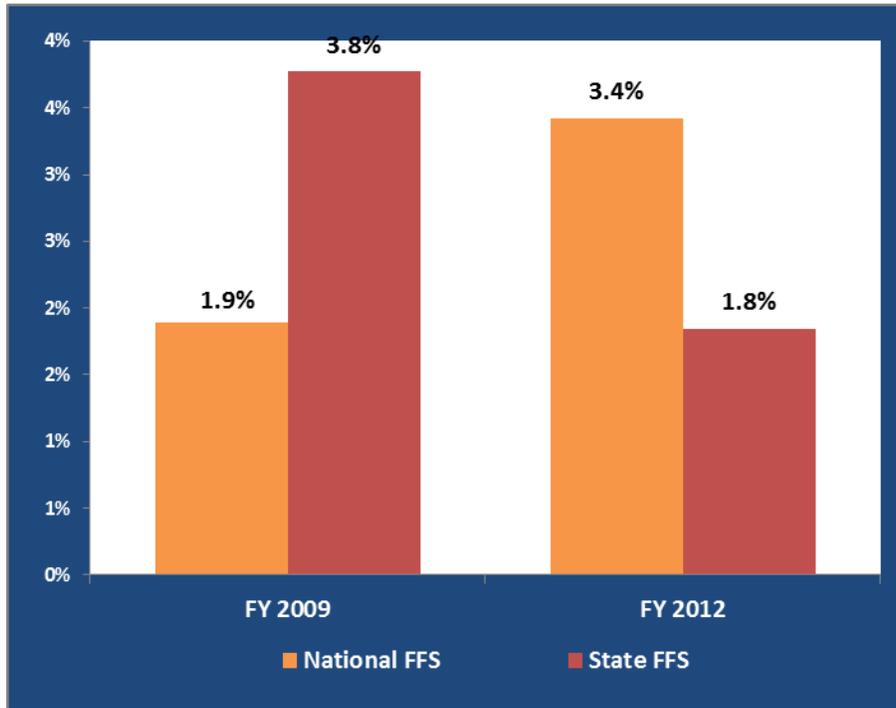
F. Comparison of Medicaid FY 2009 and FY 2012

This section provides a brief comparison of the sample findings for Pennsylvania in FY 2009 and FY 2012 for Medicaid.

Pennsylvania's Medicaid FFS Findings

Figure 7 compares the nation and Pennsylvania for FY 2009 and FY 2012. Pennsylvania's Medicaid FFS error rate was 3.8% in FY 2009 as compared to 1.8% for the FY 2012 measurement. In the most recent measurement cycle Pennsylvania's error rate was below the national average.

Figure 7: National and State Medicaid FFS Error Rates



Sample Medicaid FFS Comparisons

Table 15 summarizes the total number of errors found for Medicaid FFS in FY 2009 and FY 2012 for Pennsylvania. More errors were found in FY 2012 as compared to FY 2009.

Table 15: Comparison of Medicaid FFS Number of Errors*

Fiscal Year	Number of Errors
FY 2009	8
FY 2012	37

*If both medical review and data processing errors are found for the same claim it only appears as one error in this count

Table 16 compares Pennsylvania’s errors in FY 2012 to the number of errors found in the FY 2009 sample by Error Type.

Table 16: Medicaid FFS FY 2009 and FY 2012 Number of Errors by Type of Error

	Number of Errors In Sample	
	FY 2009	FY 2012
Medical Review Errors		
No Documentation	0	2
Insufficient Documentation	4	14
Procedure Coding Error	0	0
Diagnosis Coding Error	1	6
Unbundling	0	0
Number of Unit(s) Error	1	1
Medically Unnecessary	1	0
Policy Violation	0	3
Admin/Other	1	0
Total	8	26
Data Processing Errors		
Duplicate Item	0	0
Non-covered Service	0	0
FFS Claim for Managed Care Service	0	6
Third-party Liability	0	0
Pricing Error	0	4
Logic Edit	0	1
Data Entry Error	0	0
Rate Cell Error	0	0
Managed Care Payment Error	0	0
Admin/Other	0	0
Total	0	11

Table 17 shows a comparison of the Service Type where the errors occurred for the two fiscal years measured.

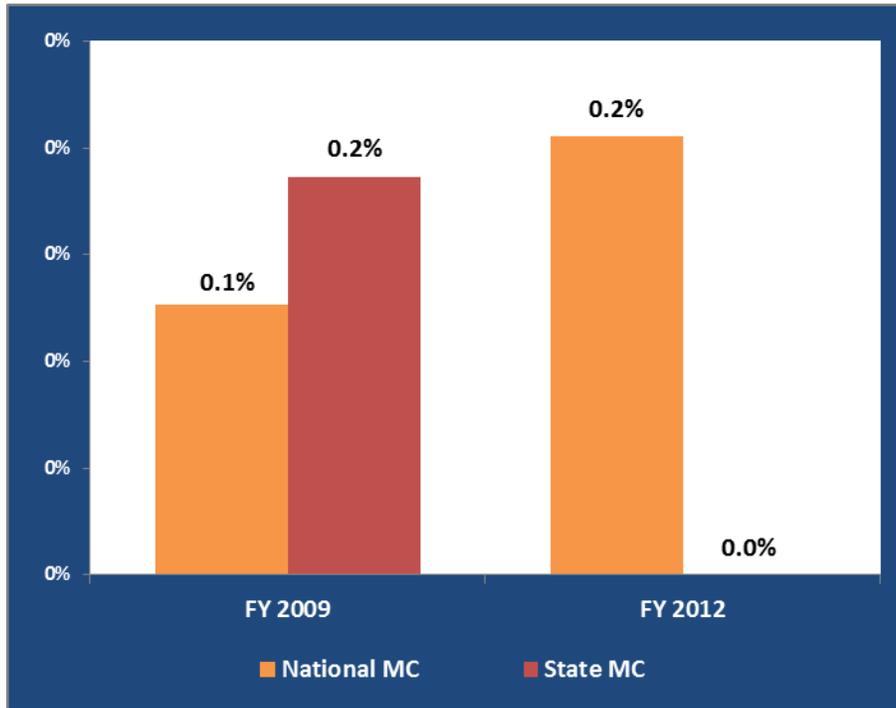
Table 17: Medicaid FFS FY 2009 and FY 2012 Number of Errors by Service Type

Service Type	FY 2009	FY 2012
Capitated Care/Fixed Payments	0	0
Crossover Claims	0	0
Denied Claims	0	1
Dental/Other Oral Surgery Services	0	0
Durable Medical Equipment (DME) Supplies/Prosthetic/Orthopedic Devices/Environmental Modifications	0	0
Habilitation/Waiver Programs	3	16
Home Health Services	1	0
Hospice Services	0	0
Inpatient Hospital	2	10
Laboratory/X-ray/Imaging Services	0	6
Managed Care	0	0
Nursing Facility/Mental Retardation/Chronic Care	2	1
Outpatient Hospital/Practitioners/Clinics	0	0
Personal Support Services	0	0
Prescribed Drugs	0	2
Psychiatric/Mental Health/Behavioral Health Services	0	1
Therapies/Hearing/Rehabilitation Services	0	0
Transportation/Accommodations	0	0
Unknown	0	0
Vision (Ophthalmology/Optometry/Optical Services)	0	0
Overall Medicaid FFS	8	37

Sample Medicaid Managed Care Comparisons

Figure 8 compares the nation and Pennsylvania for FY 2009 and FY 2012. Pennsylvania's Medicaid Managed Care error rate was 0.2% in FY 2009 as compared to 0.0% for the FY 2012 measurement. In the most recent measurement cycle Pennsylvania's error rate was below the national average.

Figure 8: National and State Medicaid Managed Care Error Rates



As shown in Table 18, Pennsylvania had 1 Managed Care error(s) noted in FY 2009 and 0 Managed Care error(s) in FY 2012.

Table 18: Medicaid Managed Care Data Processing Number of Review Errors for FY 2009 and FY 2012

Error Type	Total Number of Errors	
	FY 2009	FY 2012
Duplicate Item	0	0
Non-covered Service	0	0
FFS Claim for Managed Care Service	0	0
Third-party Liability	0	0
Pricing Error	0	0
Logic Edit	0	0
Data Entry Error	0	0
Rate Cell Error	0	0
Managed Care Payment Error	0	0
Admin/Other	1	0
Total	1	0

Sample Medicaid Eligibility Review Comparisons

Figure 9 compares the nation and Pennsylvania for FY 2009 and FY 2012. Pennsylvania’s Medicaid Eligibility error rate was 2.0% in FY 2009 as compared to 0.1% for the FY 2012

measurement. In both measurement cycles Pennsylvania’s error rate was below the national average.

Figure 9: National and State Medicaid Eligibility Error Rates

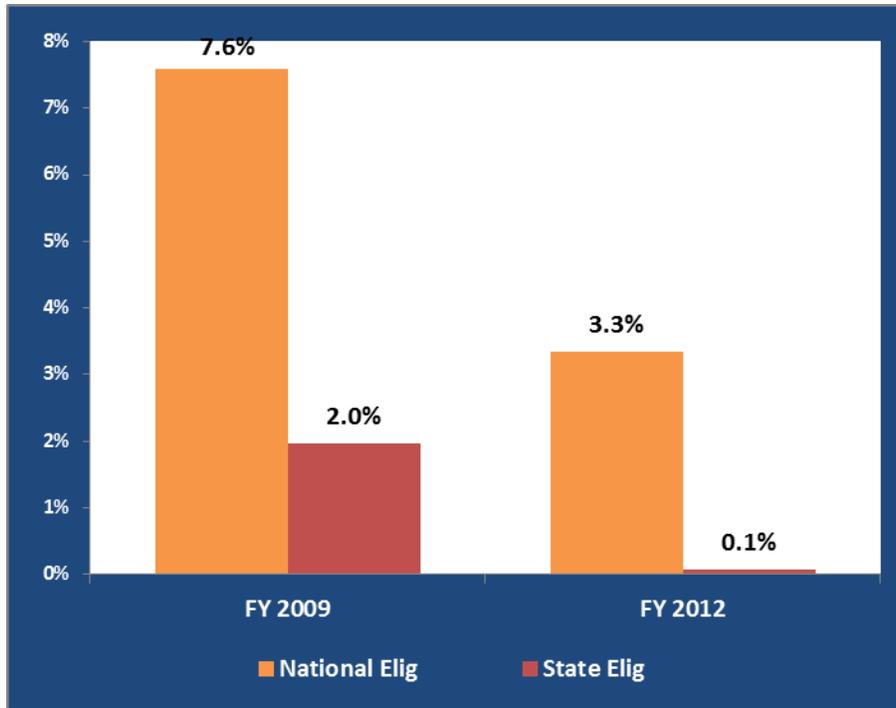


Table 19 and Table 20 compare the Eligibility Error Findings for FY 2009 and FY 2012 for Active and Negative Cases.

Table 19: Medicaid Eligibility Error Findings for FY 2009 and FY 2012

Review Finding	Active Cases Total Number of Errors		Negative Cases Total Number of Errors	
	FY 2009	FY 2012	FY 2009	FY 2012
Not Eligible	13	0	N/A	N/A
Eligible with Ineligible Services	1	0	N/A	N/A
Undetermined	7	1	N/A	N/A
Liability Understated	0	0	N/A	N/A
Liability Overstated	0	0	N/A	N/A
Managed Care Error, Ineligible for Managed Care	0	0	N/A	N/A
Managed Care Error, Eligible for Managed Care but Improperly Enrolled	0	0	N/A	N/A
Improper Denial	N/A	N/A	0	0
Improper Termination	N/A	N/A	3	0
Total Cases	21	1	3	0

Table 20: Medicaid Eligibility Error Findings by Case Action

Case Action	FY 2009	FY 2012
Application	4	1
Redetermination	12	0
All Other Active Cases	5	0
Total Active Cases	21	1

G. Recoveries

When a sampled unit is identified as an overpayment error, CMS recovers funds from the State for the federal share. Monthly Final Errors for Recoveries Reports (FEFR) are posted on the designated CMS Review Contractor’s State Medicaid Error Rate Findings (SMERF) website, which lists all claims with an overpayment error and is the official notice sent to the States of recoveries due. Attached to the report notice sent to the States is an official letter of notification from CMS.

States have up to one year from the date of discovery of an overpayment (which is the date of the monthly FEFR report) for Medicaid and CHIP to recover, or to attempt to recover the overpayment before refunding the federal share. There are exceptions, please reference the State Medicaid Directors Letter (SMDL# 10-014) dated July 13, 2010 at www.cms.gov for more details.

CMS PERM Recoveries are being reported to the Department of Health & Human Services and Congress. States must return the federal share for overpayments identified in Medicaid and CHIP FFS and managed care. States can find a comprehensive list of these overpayments in the FY 2012 End of Cycle Final Errors for Recoveries Report.

States are to work with their designated CMS Regional Office PERM Recoveries contact to ensure the appropriate federal share is returned timely. Your CMS Central Office PERM Recoveries contact is Felicia Lane who can be reached at 410-786-5787 or Felicia.Lane@cms.hhs.gov.

H. Next Steps

The corrective action process begins by establishing a corrective action panel consisting of persons within the organization who have decision-making responsibilities that affect policy and procedural change. This panel should review your State’s FY 2012 PERM findings, identify programmatic causes of the errors, determine the root causes for the errors, and develop a corrective action plan to address the major causes of these errors.

The corrective action plan should include an implementation schedule that identifies major tasks required to implement the corrective action, and timelines including target implementation dates and milestones. Monitoring and evaluation of the corrective action is also essential, to ensure that the corrective action is meeting targets and goals and is achieving the desired results.

Detailed information and instructions for submitting a corrective action plan can be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Corrective-Action-Plan-CAP-Process.html>.

CMS appreciates the cooperation extended by Pennsylvania during the FY 2012 measurement and their commitment to safeguarding taxpayers' dollars by ensuring that Medicaid services are rendered and reimbursed accurately. CMS looks forward to continuing our partnership with Pennsylvania during the CAP process. Our aim is to work closely with Pennsylvania to ensure timely submission and implementation of your State's corrective action plan. If you have any questions or concerns do not hesitate to contact Wendy Chesser from the PERM CAP Team at 410-786-8519 or Wendy.Chesser@cms.hhs.gov.