U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FY 2014 Iowa Medicaid

Payment Error Rate Measurement (PERM) Cycle 3 Summary Report

November 17, 2015

CENTERS FOR MEDICARE & MEDICAID SERVICES

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A. Program and Report Overview

The purpose of the Payment Error Rate Measurement (PERM) program is to produce a national-level improper payment rate for Medicaid and the Children's Health Insurance Program (CHIP) in order to comply with the requirements of the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012.

IPERIA is one of three acts that require federal agencies to review their programs to:

- Identify programs at risk of improper payments;
- Estimate the amount of improper payments;
- Give those estimates to Congress; and
- Report on the actions taken to reduce the improper payments.

Two programs at high risk of improper payments are Medicaid and CHIP. The Centers for Medicare & Medicaid Services (CMS) measures these improper payments annually through the PERM program. The PERM program reviews three components: 1) Fee-For-Service (FFS) claims, 2) managed care capitation payments, and 3) eligibility determinations and resulting payments. Eligibility determinations, as well as resulting payments are not included in the Fiscal Year (FY) 2014 state calculations.

While every state has operated both Medicaid and CHIP for many years, the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010, more commonly known as the Affordable Care Act (ACA), significantly affected each program by adding new requirements, expanding eligibility, and offering additional federal funding to states for eligibility system updates and development. States continue to plan and implement major changes to their Medicaid and CHIP programs to comply with the ACA and to improve accountability and quality of care.

Accordingly, the current methodologies applied to measurement of eligibility accuracy under PERM need to be updated to reflect the changes states are making in their eligibility processes and systems and incorporate new regulations concerning the changes. Therefore, for FY 2014, CMS is putting the eligibility component of PERM on hold. For reporting comprehensive Medicaid and CHIP program improper payment rates, CMS is using an estimated eligibility component rate based on historical data for continuity. This proxy rate will only have an impact on the national-level improper payment rates. All state-specific rates will be comprised of only the FFS and managed care components until eligibility is resumed for reporting in FY 2018.

This report provides an overview of the FY 2014 findings at the cycle level and presents data analyses of payment errors found in the Iowa Medicaid program. These findings, including the projected dollars in error, are meant to support the state during the corrective action process.

Reducing improper payments is a high priority for CMS and states are critical partners in the corrective action phase of the PERM cycle. States' systems, claims payment methods, provider billing errors, and provider compliance with record requests all contribute to the cycle improper payment rates in various ways. PERM identifies and classifies different types of errors, but states must conduct root cause analyses to understand why the errors occurred and how to take

corrective action. State participation is critical during the corrective action phase of the PERM cycle.

During the PERM measurement, CMS and its contractors reviewed the Medicaid FFS claims and managed care capitation payments. The first two sections of this report include the estimated 17-state cycle rates and state improper payment 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 Medicaid FFS and managed care.[1] For Medicaid FFS and managed care, additional analysis from the Review Contractor is included to address Medicaid FFS medical record and data processing errors as well as managed care data processing errors.

Note that much of the analysis provided in the document is focused on projected dollars in error, which are an estimate for how much the state paid incorrectly. The projected dollars in error are estimated by multiplying the improper payment rate by the projected paid amount. The projected paid amount is the total payment amount listed on the Medicaid and CHIP CMS 64/21 reports.

States are encouraged to use the projected dollars in error figures, which include both overpayments and underpayments, in the cycle summary reports for purposes of identifying which factors (e.g., error types, provider types) had the biggest contribution to a state's improper payment rate. The number provides a good indication of an improper payment's impact on a state's improper payment rate and can be used to appropriately target corrective actions. However, states are cautioned from taking the projected dollars in error for certain levels of analysis (for example, by error type per provider type) to be an exact reflection of the actual dollars in error because they are estimates using the PERM sample and sometimes have wide confidence intervals.

B. PERM 17-State Cycle 3 Medicaid Findings

In FY 2014, the overall Cycle 3 Medicaid estimated improper payment rate is **11.0%**. The estimated cycle component improper payment rates are as follows.

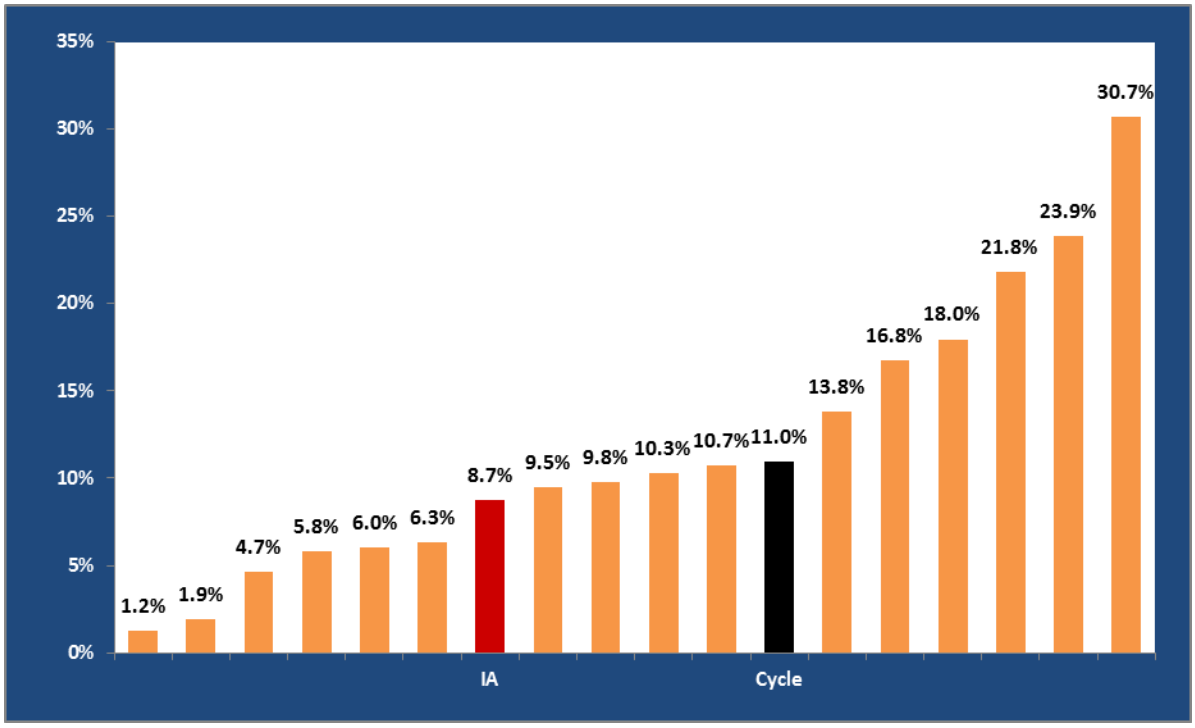
- **Medicaid FFS - 18.6%.**
- **Medicaid managed care - 0.1%.**

C. Iowa's Medicaid Findings

In FY 2014, Iowa's Medicaid estimated improper payment rate is **8.7%**. Figure 1 shows Iowa's improper payment rate compared to the Cycle 3 improper payment rate and other Cycle 3 states' improper payment rates.

[1] PERM combines components (FFS and managed care) into a single universe when a given component accounts for less than two percent of total expenditures included in the PERM universe for that state and program.

Iowa Figure 1: State Improper Payment Rate Relative to Other States and the Cycle Improper Payment Rate

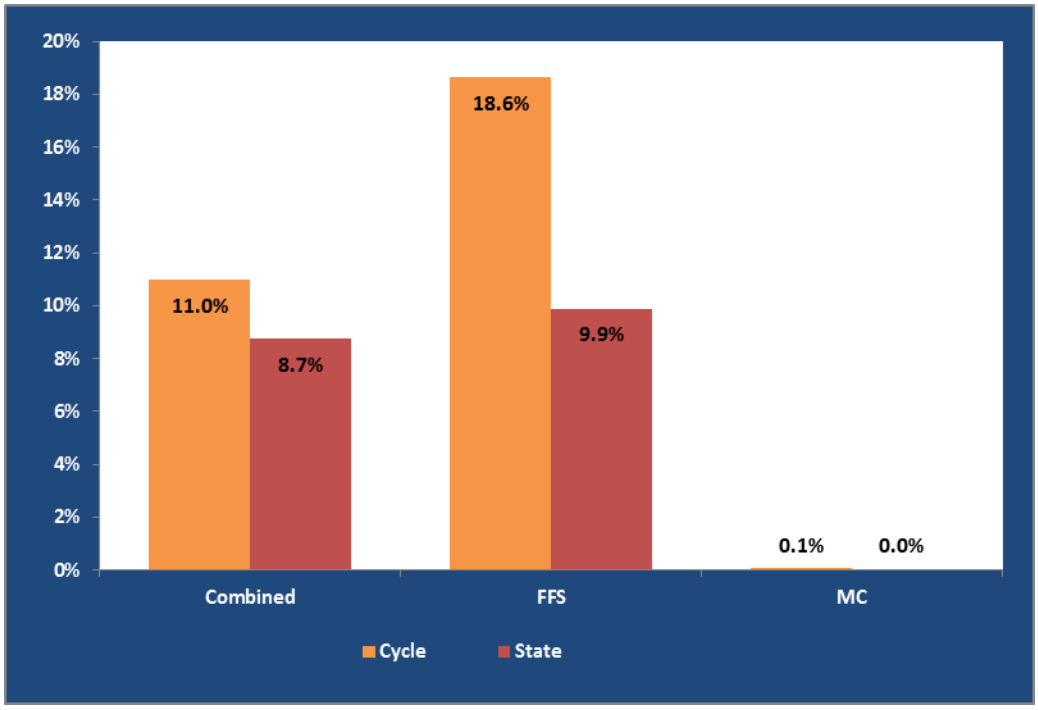


Iowa's sample review findings by component are as follows.

- **Iowa's Medicaid FFS estimated improper payment rate is 9.9%.**
- **Iowa's Medicaid managed care does not have any sampled errors.**

Figure 2 compares the 17 Cycle 3 states and Iowa on the combined improper payment rate and the component improper payment rates.

Iowa Figure 2: Cycle and State Combined and Component Improper Payment Rates



D. 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 Medicaid FFS claims are eligible for medical record review. The projected dollars in error are the claim-weighted error amounts that are used to form the numerators for each state's component improper payment rates. The weights for each sampled claim are based on the universe size from which the sample was selected (i.e., universe of Medicaid FFS claims and universe of managed care payments). Table 1 summarizes the number of errors and associated dollars for Iowa and the cycle by component. 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.

The **Projected Dollars in Error** amount is an estimate of the total dollars that may have been paid incorrectly across the program during the year. The projection assumes that the errors may be generalized to the Medicaid program in proportion to the rate and amount observed in the sample.

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

Medicaid Program Component	State				Cycle			
	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	36	$293,223	$318,590,017	100.0%	1,382	$4,390,140	$16,052	99.7%
Medicaid Managed Care	0	$0	$0	0.0%	5	$14,231	$48	0.3%

Note: Details do not always sum to the total due to rounding.

Table 2 compares Iowa's number of errors, sample dollars in error, and projected dollars in error to those found in the 17 Cycle 3 states by error type for Medicaid FFS and managed care.

Iowa Table 2: Cycle 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	Cycle	State	Cycle	State	Cycle ($Millions)
Medical Review Errors						
Insufficient Documentation	2	103	$6,809	$114,961	**$19,778,807**	**$1,209**
No Documentation	1	95	$669	$70,936	**$13,468,242**	**$470**
Number of Unit(s) Error	1	10	$358	$2,278	**$6,655,354**	**$50**
Policy Violation	0	25	$0	$40,145	**$0**	**$157**
Procedure Coding Error	0	5	$0	$1,056	**$0**	**$150**
Admin/Other	0	3	$0	$354	**$0**	**$136**
Unbundling	0	2	$0	$4	**$0**	**$1**

	Number of Errors in Sample		Sample Dollars in Error		Projected Dollars in Error	
	State	Cycle	State	Cycle	State	Cycle ($Millions)
Diagnosis Coding Error	0	0	$0	$0	**$0**	**$0**
Medically Unnecessary	0	0	$0	$0	**$0**	**$0**
Total	**4**	**243**	**$7,836**	**$229,734**	**$39,902,403**	**$2,174**
Data Processing Errors						
Non-covered Service	30	1,145	$284,612	$4,188,849	**$265,894,788**	**$14,338**
Third-party Liability	1	6	$756	$9,016	**$9,452,694**	**$156**
Pricing Error	1	37	$19	$10,330	**$3,340,132**	**$14**
Duplicate Item	0	2	$0	$15,882	**$0**	**$49**
Rate Cell Error	0	1	$0	$937	**$0**	**$9**
Logic Edit	0	1	$0	$81	**$0**	**$4**
Admin/Other	0	2	$0	$7	**$0**	**$1**
Data Entry Error	0	2	$0	$1,006	**$0**	**$0**
FFS Claim for Managed Care Service	0	0	$0	$0	**$0**	**$0**
Managed Care Payment Error	0	0	$0	$0	**$0**	**$0**
Total	**32**	**1,196**	**$285,387**	**$4,226,108**	**$278,687,615**	**$14,572**
Deficiencies						
Medical Review Deficiencies	1	17	N/A	N/A	N/A	N/A
Data Processing Deficiencies	0	4	N/A	N/A	N/A	N/A
Total	**1**	**21**	**N/A**	**N/A**	**N/A**	**N/A**
Note: Details do not always sum to the total due to rounding.						

Medicaid FFS Data Analyses

This section describes the types of Medicaid FFS payment errors. Table 3 compares Iowa's Medicaid FFS errors to the cycle Medicaid FFS errors by service type.

Iowa Table 3: Cycle and State Medicaid FFS Number of Errors and Dollars in Error by Service Type

	Number of Errors in Sample		Sample Dollars in Error		Projected Dollars in Error		Improper Payment Rate	
Service Type	**State**	**Cycle**	**State**	**Cycle**	**State ($Millions)**	**Cycle ($Millions)**	**State**	**Cycle**
ICF for the Mentally Retarded/Group Homes	15	144	$209,331	$1,380,708	$132	$2,797	59.6%	77.7%
Nursing Facility/Intermediate Care Facilities	12	316	$76,513	$1,216,758	$129	$4,999	20.4%	27.4%
Habilitation/Waiver Programs/School Services	4	107	$1,101	$212,270	$22	$2,006	3.4%	12.3%
Durable Medical Equipment (DME)/supplies/Prosthetic/Orthopedic devices/Environmental Modifications	3	25	$1,324	$22,342	$19	$199	13.7%	19.4%
Prescribed Drugs	1	213	$4,935	$253,129	$14	$1,577	3.9%	23.0%
Inpatient/Outpatient Hospital	1	85	$19	$685,218	$3	$867	0.5%	6.3%
Personal Support Services	0	54	$0	$17,384	$0	$1,007	0.0%	32.6%
Outpatient Hospital Services/Clinics	0	34	$0	$36,662	$0	$336	0.0%	14.8%
Home Health Services	0	67	$0	$17,895	$0	$331	0.0%	16.6%
Physicians/Other Licensed Practitioner Services	0	50	$0	$8,568	$0	$188	0.0%	7.7%
Laboratory/X-ray/Imaging Services	0	48	$0	$4,058	$0	$134	0.0%	28.2%
Dental/Other Oral Surgery Services	0	63	$0	$11,925	$0	$126	0.0%	13.0%
Therapies/Hearing/Rehabilitation Services	0	11	$0	$903	$0	$116	0.0%	20.5%
Crossover Claims	0	36	$0	$67,526	$0	$100	0.0%	4.6%
Capitated Care/Fixed Payments	0	5	$0	$2,456	$0	$9	0.0%	0.1%
Vision: Ophthalmology/Optometry/Optical Services	0	3	$0	$61	$0	$2	0.0%	1.1%
Denied Claims	0	1	$0	$6	$0	$0	N/A	N/A
Total	**36**	**1,262**	**$293,223**	**$3,937,867**	**$319**	**$14,794**	**9.9%**	**18.2%**

Note: Details do not always sum to the total due to rounding.

1. Medicaid FFS Medical Review – Error Type Analysis

Figure 3 shows the percentage of medical review projected dollars in error by error type.

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

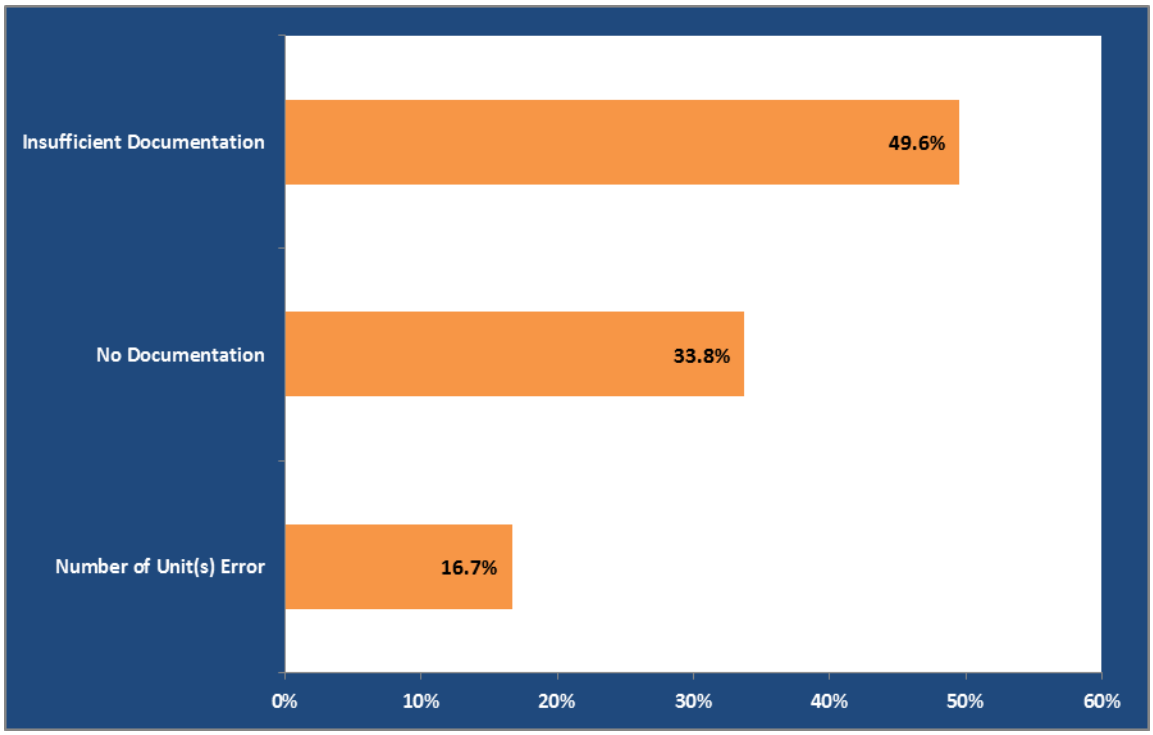


Table 4 has information regarding the number of medical review errors and dollars in error by overpayments, underpayments, and percentage of total medical review errors.

Iowa 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	2	$6,809	**$19,778,807**	0	$0	**$0**	50.0%	86.9%	**49.6%**
No Documentation	1	$669	**$13,468,242**	0	$0	**$0**	25.0%	8.5%	**33.8%**
Number of Unit(s) Error	1	$358	**$6,655,354**	0	$0	**$0**	25.0%	4.6%	**16.7%**
Total	4	$7,836	**$39,902,403**	0	$0	**$0**	100.0%	100.0%	**100.0%**

Note: Details do not always sum to the total due to rounding.

Medicaid FFS Medical Review Error Causes by Error Type

Causes Identified Include:

Insufficient Documentation

- Required progress notes applicable to DOS sampled not provided (2)

No Documentation

- Provider did not respond to the request for records (1)

Number of Unit(s) Error

- Number of units billed exceeds the number of units authorized (1)

MR1 No Documentation Error

- One no documentation error is cited because the provider did not respond to the request for records.

MR2 Insufficient Documentation Error

- Two errors are cited because the providers did not submit progress notes covering the sampled dates of service for the nursing facility claims as required by state and federal regulations.

MR6 Number of Units Error

- One error is cited because the number of units billed for personal care waiver services exceeds the number authorized. Submitted were records documenting twelve fewer units than were billed.

2. Medicaid FFS Medical Review – Service Type Analysis

The percentages of medical review projected dollars in error by service type are displayed in Figure 4.

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

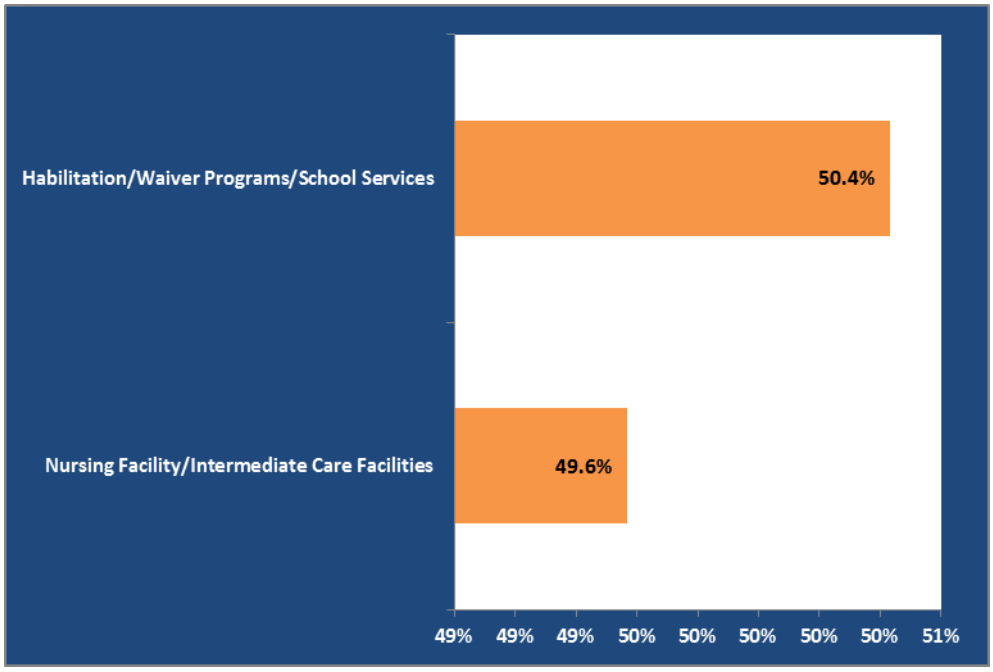


Table 5 has information regarding the number of medical review errors and dollars in error for service types by overpayments, underpayments, and percentage of total medical review errors.

Iowa 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/School Services	2	$1,027	**$20,123,596**	0	$0	**$0**	50.0%	13.1%	**50.4%**
Nursing Facility/Intermediate Care Facilities	2	$6,809	**$19,778,807**	0	$0	**$0**	50.0%	86.9%	**49.6%**
Total	4	$7,836	**$39,902,403**	0	$0	**$0**	100.0%	100.0%	**100.0%**

Note: Details do not always sum to the total due to rounding.

Table 6 shows medical review error types by service types for Medicaid FFS, including count of errors and projected dollars in error.

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

Service Type	No Documentation		Insufficient Documentation		Number of Units Error	
	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error
Habilitation/Waiver Programs/School Services	1	$13,468,242	0	$0	1	$6,655,354
Nursing Facility/Intermediate Care Facilities	0	$0	2	$19,778,807	0	$0
Total	1	$13,468,242	2	$19,778,807	1	$6,655,354

Note: Details do not always sum to the total due to rounding.

Medicaid FFS Medical Review Error Causes by Service Type

Causes Identified Include:

Habilitation/Waiver Programs/School Services

- No Documentation (1)
- Number of Unit(s) Error (1)

Nursing Facility/Intermediate Care Facilities

- Insufficient Documentation (2)

Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF)

- Two insufficient documentation errors are cited because the providers did not submit the progress notes covering the sampled dates of service for the nursing facility claims as required by state and federal regulations.

Day Habilitation and Waiver Programs, Adult Day Care, Foster Care, and School Based Services

- One number of units error is cited because the number of units billed for personal care waiver services exceeds the number authorized. Submitted were records documenting twelve fewer units than were billed.
- One no documentation error is cited because the provider did not respond to the request for records.

3. Medicaid FFS Data Processing Review – Error Type Analysis

Figure 5 shows the data processing review projected dollars in error by error type.

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

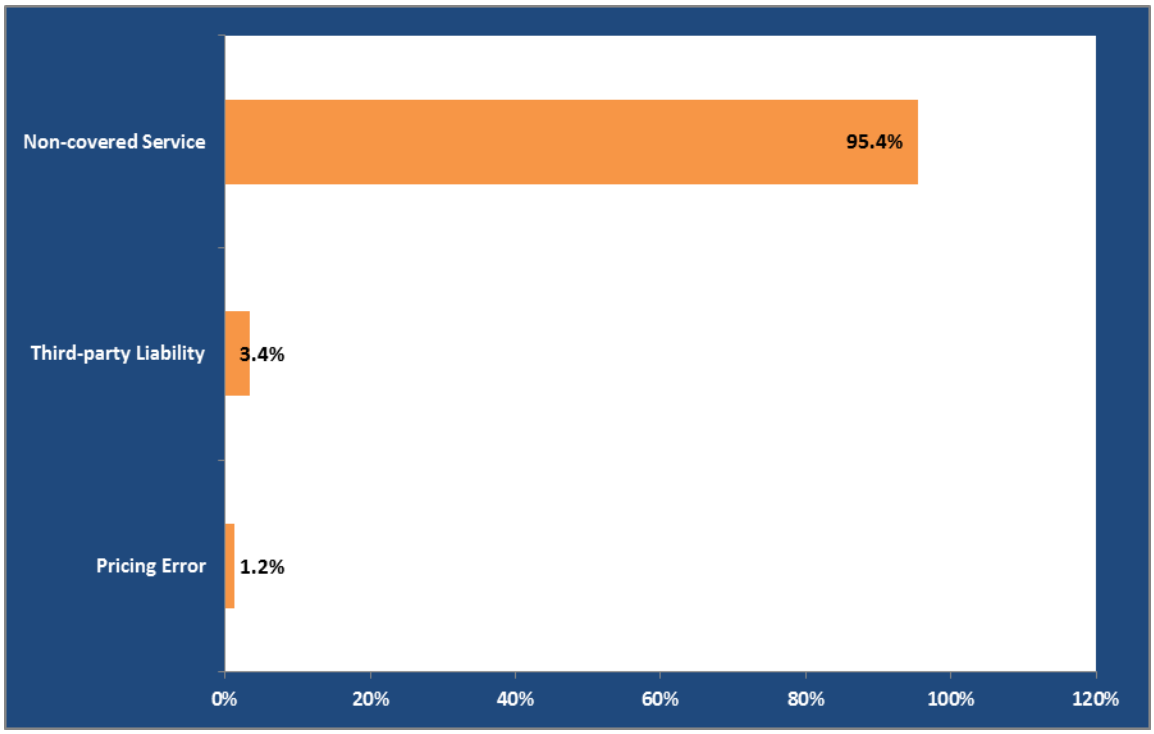


Table 7 has information regarding the number of Medicaid FFS data processing review errors and dollars in error for error types by overpayments, underpayments, and percentage of total Medicaid FFS data processing review errors.

Iowa 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
Non-covered Service	30	$284,612	**$265,894,788**	0	$0	**$0**	93.8%	99.7%	**95.4%**
Third-party Liability	1	$756	**$9,452,694**	0	$0	**$0**	3.1%	0.3%	**3.4%**
Pricing Error	1	$19	**$3,340,132**	0	$0	**$0**	3.1%	0.0%	**1.2%**
Total	32	$285,387	**$278,687,615**	0	$0	**$0**	100.0%	100.0%	**100.0%**
Note: Details do not always sum to the total due to rounding.									

Medicaid FFS Data Processing Error Causes by Error Type

Causes Identified Include:

Non-covered Service

- Attending or rendering provider required but not listed on institutional claim (17)

- Provider not enrolled in Medicaid/CHIP (6)
- New provider was not enrolled using ACA risk-based criteria (4)
- Referring/ordering provider not enrolled (2)
- Referring/ordering provider required but not listed on the claim (1)

Third-party Liability

- Payment should have been denied pending payment by TPL (1)

Pricing Error

- System input error caused incorrect pricing (1)

DP 2 – Non-Covered Services

Attending or rendering provider required but not listed on claim

- Trend: Seventeen errors totaling $166,464.99 are cited because the providers filed institutional claims but did not include the National Provider Identifier (NPI) of the attending or rendering provider as required by the HIPAA 5010 electronic claims format standards.

New provider not enrolled using ACA risk-based criteria

- Trend: Four overpayment errors totaling $47,309.58 are cited because the state does not enroll new providers after 3/24/11 using the risk-based screening requirements outlined in ACA regulations. The state did not complete all of the database checks prior to the enrollment including OIG, SAM and NPPES.

Referring/ordering provider not enrolled

- Two overpayment errors totaling $5239.75 are cited because claims for services requiring an order were paid but the ordering provider was not enrolled with the state as required by ACA regulations.

Provider not enrolled

- Trend: Six overpayment errors totaling $65,334.44 are cited because the attending providers were not enrolled in Medicaid on the date of service. These providers are required to be enrolled because they order services for recipients.

Referring/ordering provider required but not listed on claim

- One overpayment error of $263.66 is cited because a claim for services that required an order did not have the NPI of the ordering provider listed on the claim as required by ACA regulations.

DP4 – Third Party liability error

Payment should have been denied pending payment from TPL

- One overpayment error is cited in the amount of $755.75 because the recipient had active Medicare on the date of service. This information was in the state system and claim should have been denied pending the Medicare payment.

DP5 – Pricing Error

System input error caused wrong pricing

- One overpayment error of $19.31 is cited because the payment made by the system used an incorrect rate factor when calculating the payment. The wrong rate factor had been entered in association with the procedure code which caused the miscalculation.

4. Medicaid FFS Data Processing Review – Service Type Analysis

In the following section, Medicaid FFS data processing errors are analyzed by service type. Figure 6 shows the percentage of data processing review projected dollars in error by service type.

Iowa Figure 6: Medicaid FFS Data Processing Review Percentage of Projected Dollars in Error by Service Type

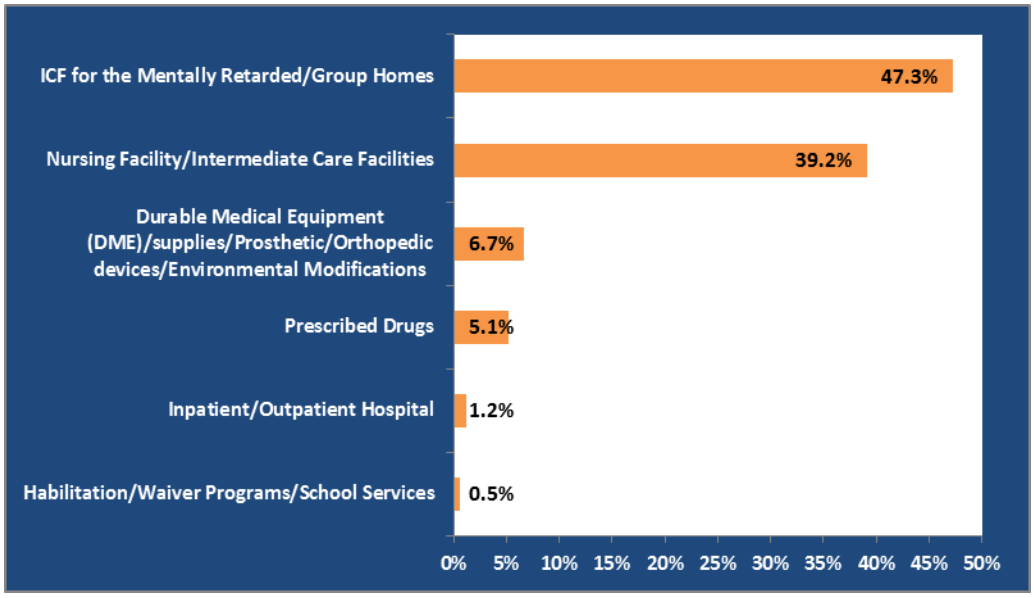


Table 8 has information regarding the number of data processing review errors and dollars in error for service types by overpayments, underpayments, and percentage of total data processing review errors.

Iowa Table 8: Medicaid FFS Data Processing Review Errors by Service Type

Service 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
ICF for the Mentally Retarded/Group Homes	15	$209,331	**$131,751,960**	0	$0	**$0**	46.9%	73.3%	**47.3%**
Nursing Facility/Intermediate Care Facilities	10	$69,704	**$109,160,194**	0	$0	**$0**	31.3%	24.4%	**39.2%**
Durable Medical Equipment (DME)/supplies/Prosthetic/Orthopedic devices/Environmental Modifications	3	$1,324	**$18,572,690**	0	$0	**$0**	9.4%	0.5%	**6.7%**
Prescribed Drugs	1	$4,935	**$14,337,836**	0	$0	**$0**	3.1%	1.7%	**5.1%**
Inpatient/Outpatient Hospital	1	$19	**$3,340,132**	0	$0	**$0**	3.1%	0.0%	**1.2%**
Habilitation/Waiver Programs/School Services	2	$74	**$1,524,803**	0	$0	**$0**	6.3%	0.0%	**0.5%**
Total	32	$285,387	**$278,687,615**	0	$0	**$0**	100.0%	100.0%	**100.0%**

Note: Details do not always sum to the total due to rounding.

Table 9 shows data processing errors by service type for Medicaid FFS, including count of errors and projected dollars in error.

Iowa Table 9: Medicaid FFS Service Type by Data Processing Review Error Type in Projected Dollars

Service Type	Non-covered Service		Third-party Liability		Pricing Error	
	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error	# of Errors	Projected Dollars in Error
Durable Medical Equipment (DME)/supplies/Prosthetic/Orthopedic devices/Environmental Modifications	2	$9,119,996	1	$9,452,694	0	$0
Habilitation/Waiver Programs/School Services	2	$1,524,803	0	$0	0	$0
ICF for the Mentally Retarded/Group Homes	15	$131,751,960	0	$0	0	$0
Inpatient/Outpatient Hospital	0	$0	0	$0	1	$3,340,132
Nursing Facility/Intermediate Care Facilities	10	$109,160,194	0	$0	0	$0
Prescribed Drugs	1	$14,337,836	0	$0	0	$0
Total	30	$265,894,788	1	$9,452,694	1	$3,340,132

Note: Details do not always sum to the total due to rounding.

Medicaid FFS Data Processing Error Causes by Service Type

Causes Identified Include:

ICF for the Mentally Retarded/Group Homes

- Non-covered Service (15)

Nursing Facility/Intermediate Care Facilities

- Non-covered Service (10)

Durable Medical Equipment (DME)/supplies/Prosthetic/Orthopedic devices/Environmental Modifications

- Non-covered Service (2)
- Third-party Liability (1)

Prescribed Drugs

- Non-covered Service (1)

Inpatient/Outpatient Hospital

- Pricing Error (1)

Habilitation/Waiver Programs/School Services

- Non-covered Service (2)

Data processing errors are typically caused by system programming errors, lack of edits in the claims system, and missing provider information, which may not be relevant to any particular type of service. Data processing errors are cited for missing provider information specifically where state Medicaid and CHIP claims processing systems paid claims that did not include referring/ordering provider National Provider Identifier (NPI), where referring/ordering providers were not enrolled in the Medicaid program as participating providers, and where newly enrolled providers are not being screened in accordance with ACA risk based screening criteria. While most of the errors for Medicaid cannot be tied to a service category, the following non-covered service error types are related to certain services.

- Non-covered service errors for “Attending/rendering provider required but not listed on institutional claim” and “Provider not enrolled in Medicaid” were cited for nursing facilities and ICF-MR group homes.

Medicaid Managed Care Data Analyses

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

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 10 lists the data processing deficiencies and medical review deficiencies found in Iowa.

Iowa Table 10: Medicaid Deficiencies Noted During PERM Claims Review

Review Type	# of Deficiencies	% of Deficiencies
Medical Review Deficiencies	1	100.0%
Data Processing Deficiencies	0	0.0%
Total Deficiencies	1	100.0%
Note: Details do not always sum to the total due to rounding.		

The causes of these findings are noted below.

Causes Identified Include:

Medical Review Deficiencies

- Procedure or diagnosis code is incorrect but does not affect payment (1)

Medical Review Deficiencies

One medical technical deficiency is cited because the provider submitted a record that included a different number of units than those billed. Documentation provided by the state indicates both paid the same dollar amount. This is considered a technical deficiency with zero dollars in error.

Data Processing Deficiencies

There are no data processing deficiencies cited for Iowa Medicaid**.**

E. Types of Payment Errors

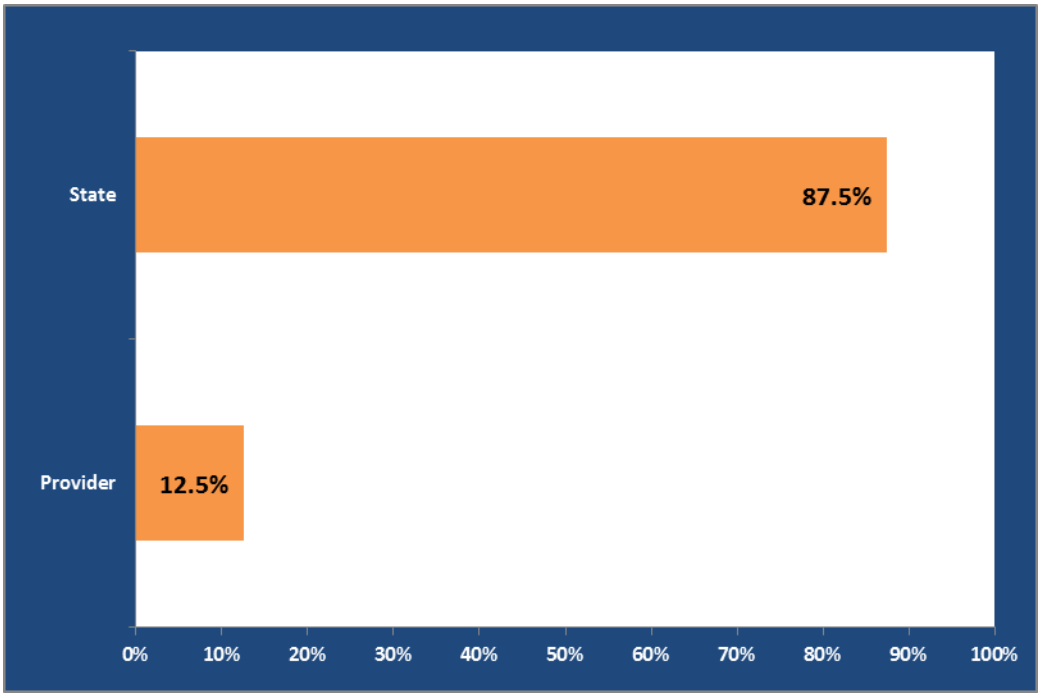
The PERM Final Rule allows for classifying data processing errors as state errors and medical review errors as provider errors. This section analyzes Iowa payment errors for FY 2014 in light of this classification. Table 11 shows how the errors aggregate into state and provider payment errors.

Iowa Table 11: 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	4	11.1%	$7,836	2.7%	**$39,902,403**	12.5%
Data Processing Errors	State	32	88.9%	$285,387	97.3%	**$278,687,615**	87.5%
Note: Details do not always sum to the total due to rounding.							

Figure 7 shows the percentage of state versus provider errors by projected dollars in error. In Iowa, state errors account for 87% of projected dollars in error, while provider errors comprise 13%.

Iowa Figure 7: Medicaid Types of Payment Errors



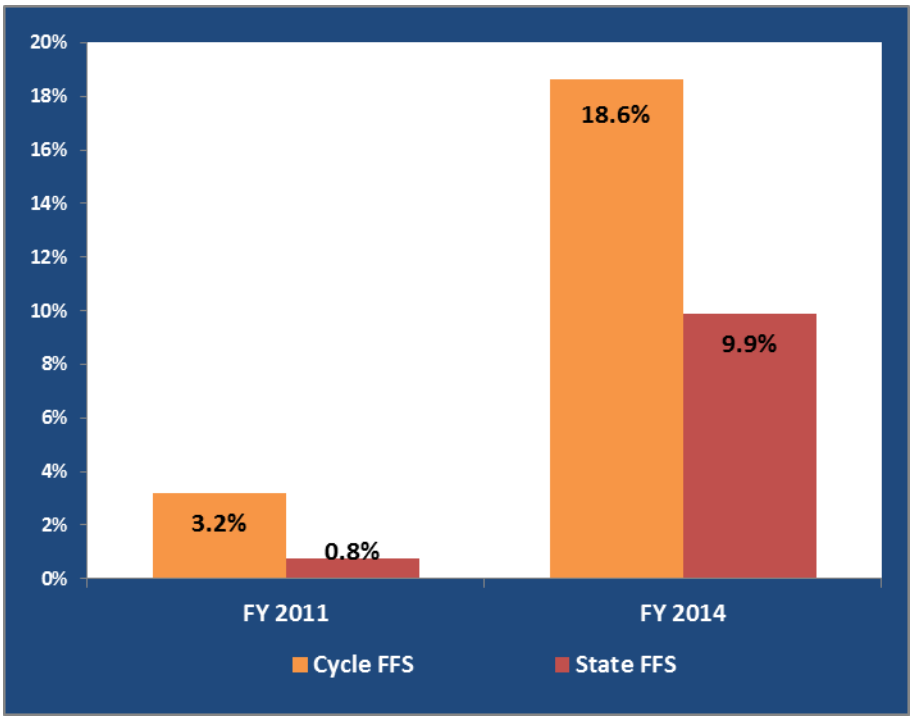
F. Comparison of Medicaid FY 2011 and FY 2014

This section provides a brief comparison of the sample findings for Iowa in FY 2011 and FY 2014 for Medicaid.

Iowa's Medicaid FFS Findings

Figure 8 compares the cycle and Iowa for FY 2011 and FY 2014. Iowa's Medicaid FFS improper payment rate was 0.8% in FY 2011 as compared to 9.9% for the FY 2014 measurement. In both measurement cycles, Iowa's improper payment rate was below the national average.

Iowa Figure 8: Cycle and State Medicaid FFS Improper Payment Rates



Sample Medicaid FFS Comparisons

Table 12 summarizes the total number of errors found for Medicaid FFS in FY 2011 and FY 2014 for Iowa.

Iowa Table 12: Comparison of Medicaid FFS Number of Errors*

Fiscal Year	Number of Errors
FY 2011	7
FY 2014	36

*Note: If both medical review and data processing errors are found for the same claim, the claim only appears as one error in this count. Since the weight for each sampled claim is based on the universe size from which the sample was selected, the number of claims in error sampled will not necessarily correlate with the projected improper payments.

Table 13 compares Iowa's errors in FY 2014 to the number of errors found in the FY 2011 sample by Error Type.

Iowa Table 13: Medicaid FFS FY 2011 and FY 2014 Number of Errors by Type of Error

	Number of Errors in Sample	
	FY 2011	FY 2014
Medical Review Errors		
No Documentation	0	1
Insufficient Documentation	2	2
Procedure Coding Error	0	0
Diagnosis Coding Error	2	0
Unbundling	0	0
Number of Unit(s) Error	1	1
Medically Unnecessary	0	0
Policy Violation	1	0
Admin/Other	0	0
Total	6	4
Data Processing Errors		
Duplicate Item	0	0
Non-covered Service	0	30
FFS Claim for Managed Care Service	0	0
Third-party Liability	0	1
Pricing Error	1	1
Logic Edit	0	0
Data Entry Error	0	0
Rate Cell Error	0	0
Managed Care Payment Error	0	0
Admin/Other	0	0
Total	1	32

Table 14 shows a comparison of the Service Type where the errors occurred for the two fiscal years measured.

Iowa Table 14: Medicaid FFS FY 2011 and FY 2014 Number of Errors by Service Type

Service Type	FY 2011	FY 2014
Capitated Care/Fixed Payments	0	0
Crossover Claims	1	0
Denied Claims	0	0
Dental and Other Oral Surgery Services	0	0

Service Type	FY 2011	FY 2014
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	0	3
Habilitation and Waiver Programs, School Services	3	4
Home Health Services	0	0
Hospice Services	0	0
ICF for the Mentally Retarded and Group Homes	0	15
Inpatient and Outpatient Hospital	2	1
Laboratory, X-ray and Imaging Services	0	0
Managed Care	0	0
Nursing Facility, Intermediate Care Facilities	0	12
Outpatient Hospital Services and Clinics	0	0
Personal Support Services	0	0
Physicians and Other Licensed Practitioner Services	0	0
Prescribed Drugs	1	1
Psychiatric, Mental Health, and Behavioral Health Services	0	0
Therapies, Hearing and Rehabilitation Services	0	0
Transportation and Accommodations	0	0
Unknown	0	0
Vision: Ophthalmology, Optometry and Optical Services	0	0
Total	7	36

Sample Medicaid Managed Care Comparisons

There were no managed care errors in Iowa in either cycle; therefore there are no managed care comparison analyses.

G. Error Type Definitions

Error type definitions for medical review error codes and data processing error codes are listed in the following tables.

Iowa Table 15: Medical Review Error Codes

Error Code	Error	Definition
MR01	No Documentation	The provider did not respond to the request for records or the provider responded that he/she did not have the requested documentation.
MR02	Insufficient Documentation	The provider did not submit sufficient documentation for the reviewer to determine whether the allowed services were provided at the level billed and/or medically necessary.

Error Code	Error	Definition
MR03	Procedure Coding Error	The provider performed a procedure or provided a medical service that was medically necessary and provided at the proper level of care, but billed and was paid using an incorrect procedure code.
MR04	Diagnosis Coding Error	The provider billed and was paid using an incorrect principal diagnosis code and /or DRG.
MR05	Unbundling	The provider billed for separate services when a CMS regulation or policy or local practice dictates that they should have been billed as a set, rather than individual services.
MR06	Number of Unit(s) Error	The provider billed for an incorrect number of units for a particular procedure/service, NDC code, or revenue code.
MR07	Medically Unnecessary	The provider billed for a service determined to have been medically unnecessary based upon the information regarding the patient's condition in the medical record.
MR08	Policy Violation	Either the provider billed and was paid for a service that was not in agreement with state policy or the provider billed and was not paid for a service that, according to state policy, should have been paid.
MR09	Administrative/Other	A payment error was discovered during a medical review, but it was not an MR01 – MR08. The specific nature of the error is recorded.

Iowa Table 16: Data Processing Error Codes

Error Code	Error	Definition
DP01	Duplicate Item	An exact duplicate of the claim or payment was previously paid.
DP02	Non-covered Service	The provider was not enrolled in Medicaid/CHIP according to federal regulations and state policy; a claim was missing required attending, referring, or ordering provider NPIs; and/or state policies indicate that the service is not payable under the state plan or for the coverage category under which the person is eligible.
DP03	Managed Care Service	The recipient is enrolled in a managed care plan and the managed care plan should have covered the service rather than being paid under FFS.
DP04	Third-party Liability	Medicaid or CHIP paid for the service as the primary payer, but a third-party carrier should have paid for the service.
DP05	Pricing Error	Payment for the service does not correspond with the pricing schedule on file and in effect for the DOS on the claim.
DP06	Logic Edit	A system edit was not in place to follow state policy or a system edit was in place, but was not working correctly and the claim was paid inappropriately.

Error Code	Error	Definition
DP07	Data Entry Error	A claim was paid in error due to clerical errors in the data entry of the claim.
DP08	Rate Cell Error	The recipient was enrolled in managed care and assigned to an incorrect rate cell, resulting in payment made according to the wrong rate cell.
DP09	Managed Care Payment Error	The recipient was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.
DP10	Administrative/Other	A payment error was discovered during a data processing review, but the error was not a DP01 – DP09 error. The specific nature of the error is recorded.

H. 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. An official letter of notification from CMS is attached to the report notice sent to the states.

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 2014 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 Wendy Chesser, who can be reached at 410-786-8519 or Wendy.Chesser@cms.hhs.gov.

I. 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 2014 PERM findings, identify programmatic causes of the errors, determine the root causes for the errors, and develop a

Corrective Action Plan (CAP) using the CMS provided Iowa CAP template to address the major causes of these errors.

The CAP 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.

The CAP is due to the assigned PERM state liaison 90 calendar days after the date on which the state's improper payment rates are posted on the Review Contractor's website. Detailed information and instructions for submitting a CAP can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Corrective-Action-Plan-CAP-Process.html.

CMS appreciates the cooperation extended by Iowa during the FY 2014 measurement and the commitment to safeguarding taxpayers' dollars by ensuring that Medicaid services are rendered and reimbursed accurately. CMS looks forward to continuing our partnership with Iowa during the CAP process. Our aim is to work closely with Iowa 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 Tracy Smith from the PERM CAP Team at 410-786-8418 or Tracy.Smith@cms.hhs.gov.