2012 Perm Error Results

In reviewing the 2012 PERM Error Results we have found areas for improvement. When providers render services to Medicaid Beneficiaries, please keep the tips listed below in mind to avoid the possibility of receiving improper payments.

Documentation:

- Was the correct documentation submitted for the correct recipient and date(s) of service?
- Does the documentation support the procedure code?
- Is the documentation sufficient to establish medical necessity?
- Is the documentation sufficient to allow reconstruction of what is being billed?
- Is the documentation specific enough to support the procedure code?
    - For example, if using a code for a particular type of ultrasound, then state the type of ultrasound within the medical record. Claim documentation must be supported within the medical record.
- Was the correct procedure code(s) submitted?
- Were the correct numbers of units documented for the submitted procedure or revenue code?
- Was a service not in agreement with a documented policy, regulation or other requirement?
- If policy requires that a signature be present for proof of delivery, then capture and include that signature.

Durable Medical Equipment/Medical Supplies:

- Original providers can contract with other suppliers to complete the order. The medical record still requires proof of delivery (signature).

Home Health/Private Duty Nursing:

- When form CMS-485 (Home Health Certification and Plan of Care) is included in the medical record, please fill out question #21 that specifies the frequency of treatments even if this is mentioned elsewhere within the medical record.

- Is the clinical record sufficiently detailed to allow reconstruction of what transpired for each billed service billed as appropriate?
    - For example, if Private Duty Nursing visited every day of a particular month, document a complete record for each day there was a visit.
    - For pre-natal care, if the record only supports up to six visits, use code 59425; however if the record supports up to seven visits, then use code 59426.
- A physician's order for Nursing Facility Admission is required.
    - For an individual who applies for Medicaid financial eligibility while a resident in a Nursing Facility (MSA Form 2565 – Facility Admission Notice), the physician must reaffirm the need for long term care for not more than thirty calendar days prior to the submission of MSA Form 2565.

Pharmacy Providers:

(*See Pharmacy Section 5 of the Medicaid Provider Manual)*

- Pharmacy providers must maintain a log containing the following information:
    - Beneficiary Name.
    - The signature of the beneficiary or of his/her representative.
    - The date of receipt of the prescription.
- The log must differentiate between prescriptions received by a beneficiary for which counseling was accepted/provided and those for which counseling was offered and declined.
- Upon request, the signature log must be in a format that enables quick and easy transfer to state or federal auditors.

In summary major causes of improper payments include:

- Missing physician's order.
- Missing signature(s).
- National or local policy requirements not met.
- Record does not support the medical necessity.
- Record is not sufficient to allow reconstruction of what is being billed.