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## PERM Definitions

*Terms defined and used in reference to the PERM review.*

**Active case:** A case containing information on a beneficiary who is enrolled in the Medicaid or CHIP (Denali KidCare) program in the month that eligibility is reviewed

**Active fraud investigation:** A beneficiary or a provider has been referred to the State Medicaid Fraud Control Unit or similar Federal or State investigative entity including a Federal oversight agency and the unit is currently actively pursuing an investigation to determine whether the beneficiary or the provider committed health care fraud. This definition applies to both the claims and eligibility.

**Adjudicated claim:** A claim that has been approved or denied.

**Adjustment:** Change to a previously submitted claim that is linked to the original claim.

**Agency:** Agency means, for purposes of the PERM eligibility reviews, the entity that performs the Medicaid and CHIP eligibility reviews under PERM and excludes the State Medicaid or CHIP agency as defined in the regulation. (See State Agency)

**Annual sample size:** The number of fee-for-service claims or eligibility cases necessary to meet precision requirements in a given PERM cycle.

**Application:** An application form for Medicaid or Denali KidCare benefits deemed complete by the State, with respect to which such State approved or denied eligibility.

**Beneficiary:** A recipient of Medicaid or Denali KidCare program benefits.

**Beneficiary liability:** The amount a beneficiary must pay toward their Medicaid services in order to maintain eligibility for Medicaid benefits. Typically liability is paid toward long term care services or home and community-based services.

**Children's Health Insurance Program (CHIP):** A program authorized and funded under Title XXI of the Social Security Act. Federal regulations governing this program are at 42 CFR Part 457. Alaska's CHIP program is known as **Denali KidCare**.

**CHIP universe:** Cases where all services are paid with Title XXI funds, including Title XXI Medicaid expansion cases that are funded under CHIP.

**Claim:** A request for payment submitted on either an approved form or electronic media, for services rendered generally relating to the care and treatment of a disease or injury or for preventative care. A claim may consist of one or several line items or services. The term "claim" is used interchangeably with the term "sampling unit."

**Denali KidCare:** see *Children's Health Insurance Program (CHIP)*

**Denied claim or line item:** A claim or line item that has been submitted to the claims processing system, adjudicated and not approved for payment in whole or in part.

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**Difference resolution:** A process that allows States to dispute the CMS contractors' error findings.

**Eligibility:** Meeting the State's categorical and financial criteria for receipt of benefits under the Medicaid or Denali KidCare programs.

**Fee-for-service (FFS):** A traditional method of paying for medical services under which providers are paid for each service rendered.

**FFS processing error:** A payment error that can be determined from the information available on the claim or from other information available in the State Medicaid/ Denali KidCare systems (exclusive of medical reviews and eligibility reviews).

**Health Insurance Premium Payment (HIPP) program:** A program allowing States to choose to have Medicaid or Denali KidCare pay for beneficiaries' private health insurance premiums when it is more cost-effective than paying for the full cost of Medicaid services.

**Improper payment:** Any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible beneficiary, any duplicate payment, any payment for services not received and any payment incorrectly denied.

**Last action:** The most recent date on which the State agency took action to grant, deny or terminate program benefits based on the State agency's eligibility determination; and is the point in time for the PERM eligibility reviews unless the last action occurred outside of 12 months prior to the sample month.

**Line item:** An individually-priced service presented on a claim for payment. Items individually listed but priced in a bundled service rather than being priced individually are not considered "line items."

**Managed care:** A system where the State contracts with health plans on a prospective full-risk or partial-risk basis, to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for specific services delivered. The State of Alaska Medicaid Program does not have a Managed care program.

**Managed Care Organization (MCO):** An entity that has entered into a risk contract with a State Medicaid and/or CHIP agency to provide a specified package of benefits to Medicaid and/or CHIP enrollees. The MCO assumes financial responsibility for services delivered and is responsible for contracting with and reimbursing servicing providers. State payments to MCOs are typically done on the basis of a monthly capitation payment per enrolled beneficiary. The State of Alaska Medicaid Program does not have a Managed care program.

**Medicaid:** A joint Federal and State program, authorized under Title XIX of the Social Security Act (the Act) that provides medical care to people with low incomes and limited resources.

**Medicaid universe:** Cases where all services are paid with Title XIX funds.

**Medicaid Statistical Information System (MSIS):** The MSIS, housed by CMS, collects statistical data from each of the States on an annual basis (using form HCFA-2082). The system includes aggregated statistical data on beneficiaries, services, and expenditures during a Federal fiscal year (i.e., October 1 through September 30).

**Medical review error:** An error that is determined from a review of the medical documentation in conjunction with State medical policies and information presented on the claim.

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**Medicare:** The federal health insurance program for people 65 years of age or older and certain younger people with disabilities or End Stage Renal Disease.

**Negative case:** A case containing information on a beneficiary who applied for benefits and was denied or whose program benefits were terminated based on the State agency's eligibility determination.

**Non-claims based sampling unit:** Sampling units that are not related to a particular service provided, such as Medicare Part A or Part B premiums.

**Overpayment:** Overpayments occur when the State pays more than the amount the provider was entitled to receive or paid more than its share of the cost.

**Paid claim:** A claim or line item that was accepted by the claims processing or payment system, adjudicated for payment, determined to be a covered service eligible for payment, and for which a payment was issued or for which no payment was made due to circumstances such as payment by a third party insurer. (See Zero Paid Claim)

**Partial error:** Partial errors are those that affect only a portion of the payment on a claim.

**Payment:** Any payment to a provider or insurer for a Medicaid or Denali KidCare beneficiary for which there is Federal financial participation.

**Payment error rate:** An annual estimate of improper payments made under Medicaid and CHIP equal to the sum of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

**Payment review:** The process by which payments made for services are associated with cases reviewed for eligibility. Payments are collected for services received in the review month, the first 30 days of eligibility or the sample month, depending on the case and stratum being reviewed.

**Provider error:** This includes, but is not limited to, medical review errors as described in § 431.960(c) of this subpart, as determined in accordance with documented State or Federal policies or both.

**Sample:** A random sample of claims or cases selected from the universe (see "universe" definition below).

**Sampling unit:** The sampling unit for each sample is an individually priced service (e.g., a physician office visit, a hospital stay, or a monthly Medicare premium). Depending on the universe, the sampling unit includes: claim, line item or premium payment. The term "claim" is used interchangeably with the term "sampling unit."

**State agency:** The State agency that is responsible for determining program eligibility for Medicaid and Denali KidCare as applicable based on applications and redeterminations.

**State error:** This includes, but is not limited to, data processing errors and eligibility errors as described in § 431.960(b) and (d) of this subpart, as determined in accordance with documented State or Federal policies or both.

**Third party liability (TPL):** The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. In cases of available TPL, Medicaid is payer of last resort.

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**Technical errors:** Errors that do not result in a difference between the amount that was paid and the amount that should have been paid (i.e. an improper payment).

**Underpayment:** A payment made by the State that is less than the amount the provider was entitled to receive or less than its share of cost.

**Universe:** The universe is the set of sampling units from which the sample for a particular program area is drawn and the set of payments for which the error rate is inferred from the sample. The term “claim” is used interchangeably with the term “sampling unit.”

**Zero-paid claim:** A claim or line item that has been approved for payment, and for which the actual amount remitted was zero dollars. This can occur due to third-party liability, application of deductibles, or other causes.