

## § 431.970

purposes. Only dollars in error will factor into a State's PERM error rate.

[75 FR 48848, Aug. 11, 2010]

### § 431.970 Information submission requirements.

(a) States must submit information to the Secretary for, among other purposes, estimating improper payments in Medicaid and CHIP, that include but are not limited to—

(1) Adjudicated fee-for-service (FFS) or managed care claims information or both, on a quarterly basis, from the review year;

(2) Upon request from CMS, provider contact information that has been verified by the State as current;

(3) All medical and other related policies in effect and any quarterly policy updates;

(4) Current managed care contracts, rate information, and any quarterly updates applicable to the review year for CHIP and, as requested, for Medicaid;

(5) Data processing systems manuals;

(6) Repricing information for claims that are determined during the review to have been improperly paid;

(7) Information on claims that were selected as part of the sample, but changed in substance after selection, for example, successful provider appeals;

(8) Adjustments made within 60 days of the adjudication dates for the original claims or line items with sufficient information to indicate the nature of the adjustments and to match the adjustments to the original claims or line items;

(9) For the eligibility improper payment measurement, information as set forth in §§ 431.978 through 431.988;

(10) A corrective action plan for purposes of reducing erroneous payments in FFS, managed care, and eligibility; and

(11) Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining error rates in Medicaid and CHIP.

(b) Providers must submit information to the Secretary for, among other purposes estimating improper payments in Medicaid and CHIP, which include but are not limited to, Medicaid

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and CHIP beneficiary medical records within 75 calendar days of the date the request is made by CMS. If CMS determines that the documentation is insufficient, providers must respond to the request for additional documentation within 14 calendar days of the date the request is made by CMS.

[71 FR 51081, Aug. 28, 2006, as amended at 72 FR 50513, Aug. 31, 2007; 75 FR 48848, Aug. 11, 2010]

### § 431.972 Claims sampling procedures.

(a) *Claims universe.* (1) The PERM claims universe includes payments that were originally paid (paid claims) and for which payment was requested but denied (denied claims) during the FFY, and for which there is FFP (or would have been if the claim had not been denied) through Title XIX (Medicaid) or Title XXI (CHIP).

(2) The State must establish controls to ensure FFS and managed care universes are accurate and complete, including comparing the FFS and managed care universes to the Form CMS-64 and Form CMS-21 as appropriate.

(b) *Sample size.* CMS estimates a State's annual sample size for claims review at the beginning of the PERM cycle.

(1) *Precision and confidence levels.* The annual sample size should be estimated to achieve a State-level error rate within a 3 percent precision level at 95 percent confidence interval for the claims component of the PERM program, unless the precision requirement is waived by CMS on its own initiative.

(2) *Base year sample size.* The annual sample size in a State's first PERM cycle (the "base year") is—

(i) Five hundred fee-for-service claims and 250 managed care payments drawn from the claims universe; or

(ii) If the claims universe of fee-for-service claims or managed care capitation payments from which the annual sample is drawn is less than 10,000, the State may request to reduce its sample size by the finite population correction factor for the relevant PERM cycle.

(3) *Subsequent year sample size.* In PERM cycles following the base year:

(i) CMS considers the error rate from the State's previous PERM cycle to determine the State's annual sample size for the current PERM cycle.