§ 431.960 Types of payment errors.

(a) General rule. State or provider errors identified for the Medicaid and CHIP improper payments measurement under the Improper Payments Information Act of 2002 must affect payment under applicable Federal policy or State policy or both.

(b) Data processing errors.

(1) A data processing error is an error resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the State’s Medicaid system.
Management Information System, related systems, or outside sources of provider verification.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with the State’s documented policies, is the dollar measure of the payment error.

(3) Data processing errors include, but are not limited to the following:
   (i) Payment for duplicate items.
   (ii) Payment for non-covered services.
   (iii) Payment for fee-for-service claims for managed care services.
   (iv) Payment for services that should have been paid by a third party but were inappropriately paid by Medicaid or CHIP.
   (v) Pricing errors.
   (vi) Logic edit errors.
   (vii) Data entry errors.
   (viii) Managed care rate cell errors.
   (ix) Managed care payment errors.
   (c) Medical review errors. (1) A medical review error is an error resulting in an overpayment or underpayment that is determined from a review of the provider’s medical record or other documentation supporting the service(s) claimed, Code of Federal Regulations that are applicable to conditions of payment, the State’s written policies, and a comparison between the documentation and written policies and the information presented on the claim.
   (2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with 42 CFR 440 to 484.55 of the Code of Federal Regulations that are applicable to conditions of payment and the State’s documented policies, is the dollar measure of the payment error.
   (3) Medical review errors include, but are not limited to the following:
      (i) Lack of documentation.
      (ii) Insufficient documentation.
      (iii) Procedure coding errors.
      (iv) Diagnosis coding errors.
      (v) Unbundling.
      (vi) Number of unit errors.
      (vii) Medically unnecessary services.
      (viii) Policy violations.
      (ix) Administrative errors.
   (d) Eligibility errors. (1) An eligibility error includes, but is not limited to, errors determined by applying Federal rules and the State’s documented policies and procedures, resulting from services being provided to an individual who meets at least one of the following provisions:
      (i) Was ineligible when authorized as eligible or when he or she received services.
      (ii) Was eligible for the program but was ineligible for certain services he or she received.
      (iii) Lacked or had insufficient documentation in his or her case record, in accordance with the State’s documented policies and procedures, to make a definitive review decision of eligibility or ineligibility.
      (iv) Overpaid the assigned liability due to the individual’s liability being understated.
      (v) Underpaid toward assigned liability due to the individual’s liability being overstated.
   (3) A State eligibility error does not result from the State’s verification of an applicant’s self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant’s self-declaration or self-certification satisfies the requirements in Federal law, guidance, or if applicable, Secretary approval.
   (4) Negative case errors are errors, based on the State’s documented policies and procedures, resulting from either of the following:
      (i) Applications for Medicaid or CHIP that are improperly denied by the State.
      (ii) Existing cases that are improperly terminated from Medicaid or CHIP by the State.
   (5) No payment errors are associated with negative cases.
   (e) Errors for purposes of determining the national error rates. The Medicaid
§ 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 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.

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