U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FY 2011 Louisiana Medicaid

Payment Error Rate Measurement (PERM) Cycle 3 Summary Report

November 21, 2012

Louisiana - PERM Findings FY 2011

Data Analysis for Medicaid Corrective Action Plan

This report provides an overview of the FY 2011 Payment Error Rate Measurement (PERM) findings at the national level and then presents data analyses of payment errors found in the Louisiana PERM sample and projected dollars in error from the same sample. The PERM corrective action process supports the identification and implementation of cost-effective approaches to reduce error. PERM identifies and classifies types of errors but States must conduct root cause analysis to identify why the errors occur, a necessary precursor to effective corrective action. Thus, your participation is critical during the corrective action phase of the PERM cycle.

We reviewed the Medicaid claims for fee-for-service (FFS) and managed care. States reviewed eligibility cases. The first two sections of this report include the estimated national and State error 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. Also included is a summary of the Louisiana Medicaid PERM review from the perspective of the Review Contractor.

A. PERM National Medicaid Findings

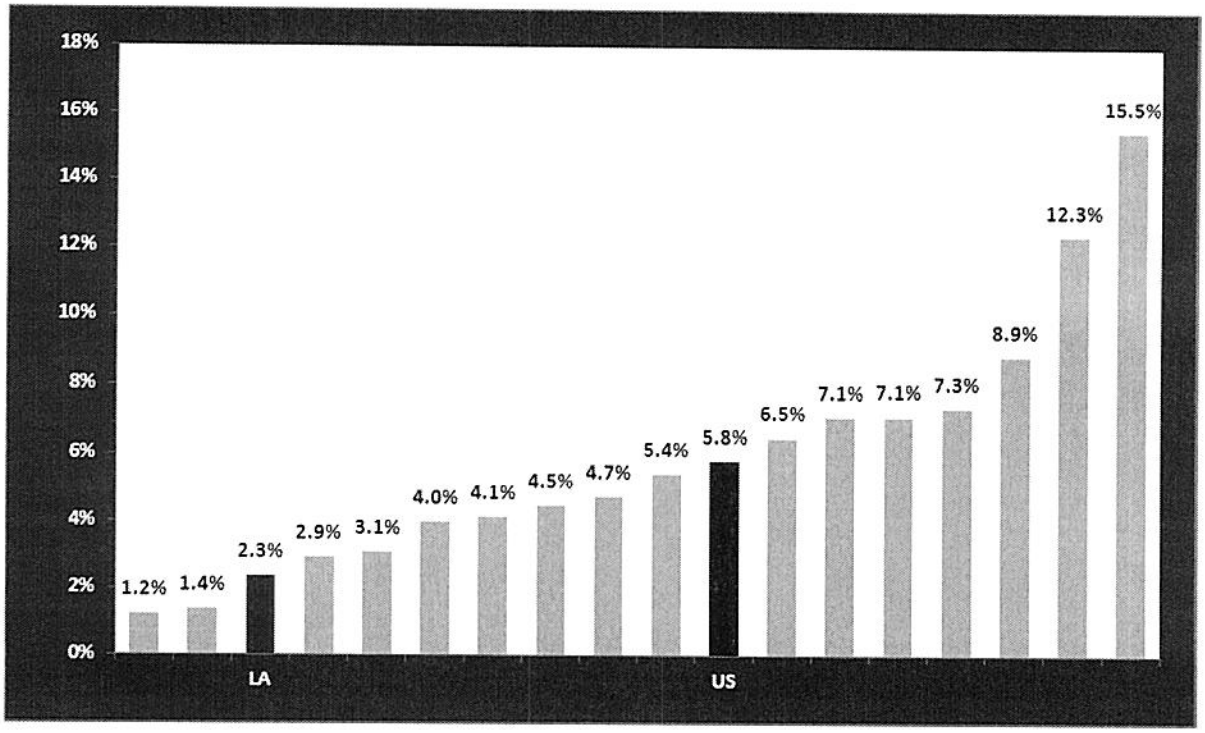
In FY 2011 the overall national Medicaid estimated error rate is **5.8%**. All States measured had a Medicaid FFS program, and 12 had a Medicaid managed care program. The review findings include:

- **The national Medicaid FFS estimated error rate is 3.3%.**
  - For Medicaid FFS medical record reviews, the largest sources of projected dollars in error are due to Insufficient Documentation, No Documentation, and Policy Violation.
  - For Medicaid FFS, projections show the most costly errors by service type are for "Psychiatric, Mental Health, and Behavioral Health Services" and "Nursing Facility, Intermediate Care Facilities".
  - For Medicaid FFS data processing reviews, the largest sources of projected dollars in error are due to Logic Edit, Non-covered Service, and FFS Claim for Managed Care Service.
- **The national Medicaid managed care estimated error rate is 0.3%.**
  - The largest source of projected dollars in error is due to Non-covered Service.
- **The national Medicaid eligibility component estimated error rate is 3.3%.**
  - The largest sources of projected dollars in error are for Not Eligible, Undetermined, and Eligible with Ineligible Services.

B. Louisiana's Medicaid Findings

In FY 2011 Louisiana's Medicaid estimated error rate is **2.3%**. Figure 1 displays Louisiana's error rate compared to the national and other FY 2011 States' error rates.

Figure 1: State Error Rate Relative to Other States and the National Error Rate

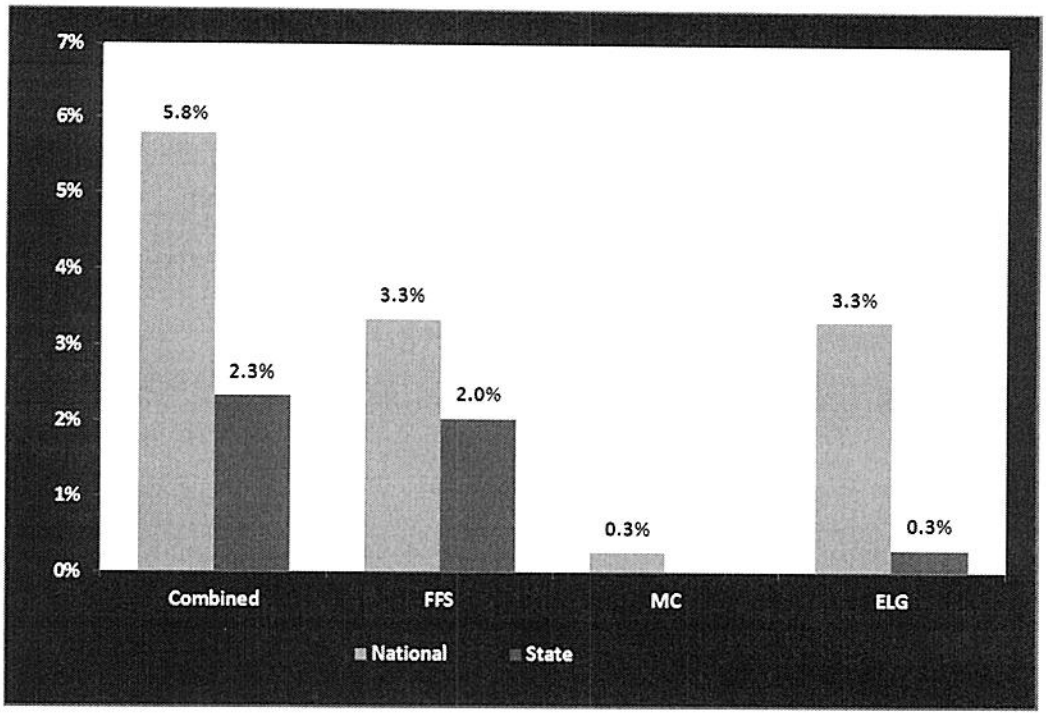


Louisiana's sample review findings include:

- **Louisiana's Medicaid FFS estimated error rate is 2.0%.**
  - For Medicaid FFS medical record reviews, the largest sources of projected dollars in error are due to No Documentation and Policy Violation.
  - For Medicaid FFS, projections show the most costly error by service type is for "Nursing Facility, Intermediate Care Facilities".
  - For Medicaid FFS data processing reviews, the largest source of projected dollars in error is due to Pricing Error.
- **Louisiana's Medicaid eligibility component estimated error rate is 0.3%.**
  - For Medicaid eligibility, the largest source of projected dollars in error is due to Not Eligible.

Figure 2 compares the nation and Louisiana on the combined error rate and the component error rates.

Figure 2: National and State Combined and Component Error Rates



C. 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) list all claims with an overpayment error and is the official notice sent to the States of recoveries due. Attached to the report notice sent to the States is an official letter of notification from CMS.

For overpayments that were identified on or after March 23, 2010, recoveries to CMS for the federal share are required within 1 year of the receipt of the monthly FEFR report posted on the designated CMS review contractor's website. See the State Medicaid Directors Letter (SMDL# 10-014) dated July 13, 2010 for more details.

CMS PERM Recoveries are being reported to the Department of Health & Human Services and Congress. For Cycle 3 (FY 2011), States must return the federal share for overpayments identified in Medicaid and CHIP Fee-for-Service and Managed Care. The end of the cycle Year-To-Date (YTD) Final Errors for Recoveries Reports will be sent out in December 2012 along with the official notification letters via email.

States are to work with their designated CMS Regional Office PERM Recoveries contact in order to ensure the appropriate federal share is returned timely. Your CMS Central Office PERM Recoveries contact is Felicia Lane who can be reached at 410-786-5787 or Felicia.Lane@cms.hhs.gov.

D. 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 the enclosed FY 2011 PERM Findings prepared specifically for your State, identify programmatic causes of the errors, determine the root causes for the errors, and develop a corrective action plan to address the major causes of these errors.

In analyzing the data, please focus your efforts on major causes of error where you can identify clear patterns. For example, several States have found that particular provider types such as pharmacies or long term care facilities repeatedly fail to comply with documentation requirements, and have determined that a targeted corrective action for these providers is cost-effective and likely to reduce future improper payments. Some States have found it cost-effective to place first priority on errors that are wholly within their control (e.g., pricing and logic errors in the processing system, eligibility errors), then on provider or client errors with clear patterns where education or clarification is likely to result in improvement (e.g., a dozen medical review policy errors due to lack of provider signatures, five pharmacy errors due to missing original scripts), then on distinctive provider errors that can only be addressed through individual provider follow-up and general provider education.

The corrective action plan 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.
CMS will be scheduling a State Forum call to allow States to discuss best practices on how to develop a CAP program. This will be a State led call. Additional details will be forwarded to you as they become available.

CMS appreciates the cooperation extended by Louisiana during the FY 2011 measurement and their commitment to safeguarding taxpayers' dollars by ensuring that Medicaid services are rendered and reimbursed accurately. CMS looks forward to continuing our partnership with Louisiana during the CAP process.

My aim is to work closely with you to ensure timely submission and implementation of your State's corrective action plan. If you have any questions or concerns do not hesitate to call me at 410-786-5787 or email me at Felicia.Lane@cms.hhs.gov. The submission due date for the corrective action plan is February 15, 2013.

I look forward to working with you on developing an effective corrective action plan that will reduce errors and prevent improper payments in the future.

Sincerely,
Felicia Lane
PERM CAP Team
CMS/OFM/PCG
Division of Error Rate Measurement

E. 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, where applicable, medical record review. Only FFS claims can be 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 error rates. Table 1 summarizes the number and dollars in error for Louisiana and the national samples for each component of PERM. 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.

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

Medicaid Program Component	State			National		
	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error ($millions)
Medicaid FFS	21	$30,579	$132,101,989	306	$1,642,138	$10,570
Medicaid Managed Care	N/A	N/A	N/A	43	$11,115	$272
Medicaid Eligibility	1	$115	$19,682,850	311	$125,757	$13,994

Table 2 below compares Louisiana's errors to the number and dollar value of errors found in the 17 State sample, by error type as well as the projected dollars in error.

Table 2: National 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	National	State	National	State	National ($Millions)
Medical Review Errors						
Insufficient Documentation	2	72	$3,595	$121,942	**$16,625,073**	**$2,240**
No Documentation	10	43	$12,915	$51,383	**$74,147,994**	**$1,273**
Number of Unit(s) Error	0	33	$0	$87,493	**$0**	**$394**
Policy Violation	4	32	$12,405	$71,570	**$26,035,227**	**$861**
Diagnosis Coding Error	0	12	$0	$137,433	**$0**	**$317**
Admin/Other	0	8	$0	$4,810	**$0**	**$162**
Procedure Coding Error	1	3	$106	$230	**$7,307,923**	**$67**
Medically Unnecessary	1	1	$1,457	$1,457	**$2,952,462**	**$12**
Unbundling	0	0	$0	$0	**$0**	**$0**
Total	**18**	**204**	**$30,478**	**$476,320**	**$127,068,679**	**$5,326**

	Number of Errors in Sample		Sample Dollars in Error		Projected Dollars in Error	
	State	National	State	National	State	National ($Millions)
Data Processing Errors						
Pricing Error	3	60	$102	$880,497	**$5,033,310**	**$211**
Managed Care Payment Error	0	28	$0	$0	**$0**	**$0**
Non-covered Service	0	26	$0	$6,533	**$0**	**$730**
Logic Edit	0	18	$0	$176,597	**$0**	**$4,130**
FFS Claim for Managed Care Service	0	6	$0	$82,344	**$0**	**$247**
Duplicate Item	0	6	$0	$8,915	**$0**	**$14**
Third-party Liability	0	4	$0	$5,618	**$0**	**$207**
Admin/Other	0	3	$0	$17,574	**$0**	**$79**
Rate Cell Error	0	1	$0	$28	**$0**	**$0**
Data Entry Error	0	0	$0	$0	**$0**	**$0**
Total	**3**	**152**	**$102**	**$1,178,106**	**$5,033,310**	**$5,619**
Eligibility Errors (Active Cases)						
Not Eligible	1	207	$115	$89,467	**$19,682,850**	**$8,483**
Undetermined	0	47	$0	$20,857	**$0**	**$3,401**
Liability Understated	0	28	$0	$5,684	**$0**	**$660**
Eligible with Ineligible Services	0	13	$0	$7,333	**$0**	**$930**
Liability Overstated	0	11	$0	$2,374	**$0**	**$508**
Managed Care Error, Eligible for Managed Care but Improperly Enrolled	0	3	$0	$41	**$0**	**$12**
Managed Care Error, Ineligible for Managed Care	0	2	$0	$0	**$0**	**$0**
Total	**1**	**311**	**$115**	**$125,757**	**$19,682,850**	**$13,994**
Eligibility Errors (Negative Cases)						
Improper Termination	0	135	N/A	N/A	N/A	N/A
Improper Denial	0	60	N/A	N/A	N/A	N/A
Total	**0**	**195**	**N/A**	**N/A**	**N/A**	**N/A**

Medicaid FFS Data Analyses

This section provides an analytical description of the reasons for Medicaid FFS payment errors.

1. Medicaid FFS Medical Review

The top reason(s) for Medicaid FFS **medical review errors** in terms of projected dollars in error are:

- No Documentation
- Policy Violation
- Insufficient Documentation
- Procedure Coding Error

As shown in Figure 3, 78.8% of the projected medical review dollars in error can be attributed to No Documentation and Policy Violation. Insufficient Documentation, Procedure Coding Error, and Medically Unnecessary comprise the remaining 21.2%.

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

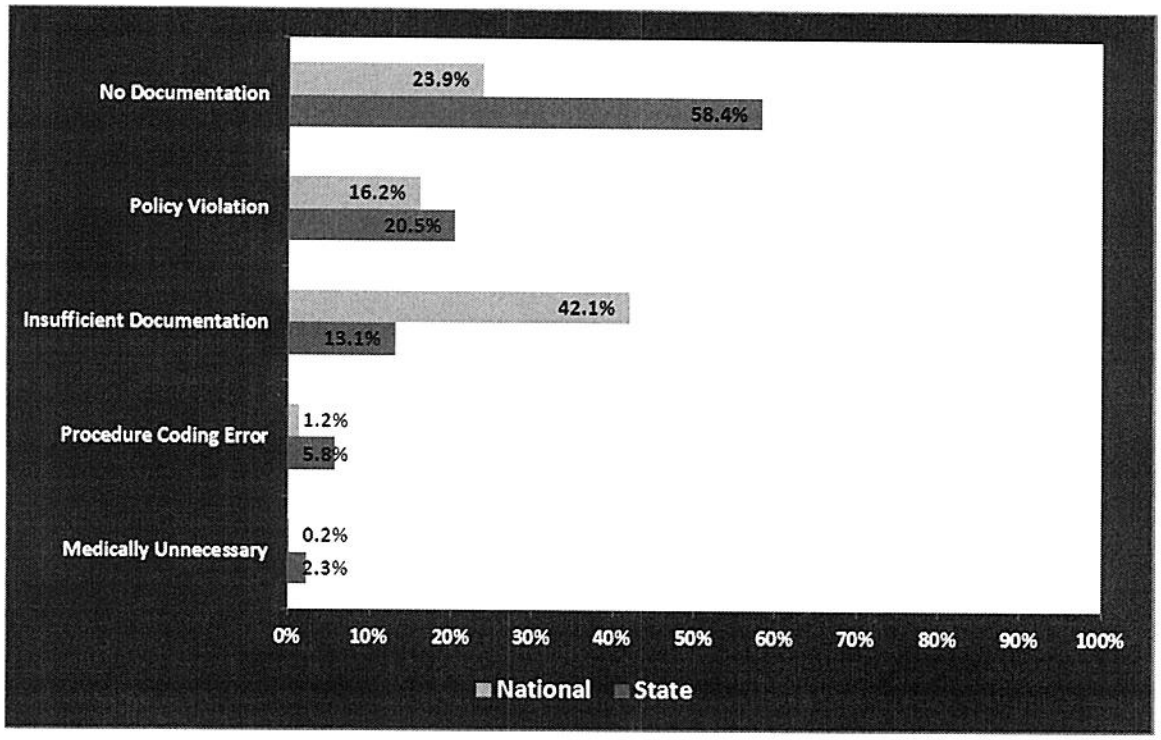


Table 3 has more information regarding the number of medical review errors and dollars in error by overpayments, underpayments, and percentage of total medical review errors.

No Documentation accounts for 58.4%, Policy Violation accounts for 20.5%, Insufficient Documentation accounts for 13.1%, Procedure Coding Error accounts for 5.8%, and Medically Unnecessary accounts for 2.3% of the projected medical review dollars in error.

Table 3: 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
No Documentation	10	$12,915	**$74,147,994**	0	$0	**$0**	55.6%	42.4%	**58.4%**
Policy Violation	4	$12,405	**$26,035,227**	0	$0	**$0**	22.2%	40.7%	**20.5%**
Insufficient Documentation	2	$3,595	**$16,625,073**	0	$0	**$0**	11.1%	11.8%	**13.1%**
Procedure Coding Error	1	$106	**$7,307,923**	0	$0	**$0**	5.6%	0.3%	**5.8%**
Medically Unnecessary	1	$1,457	**$2,952,462**	0	$0	**$0**	5.6%	4.8%	**2.3%**
Total	18	$30,478	**$127,068,679**	0	$0	**$0**	100.0%	100.0%	**100.0%**

Common Causes for Medicaid FFS Medical Review Errors by Error Type

No Documentation

- Other
- Provider submitted record after the cycle cut off date

Policy Violation

- Documentation does not meet the State policy requirements for the service performed.

Insufficient Documentation

- Provider did not supply sufficient documentation to support the claim.

The percentages of medical review dollars in error by service type are displayed in Figure 4. As shown, errors found in "Nursing Facility, Intermediate Care Facilities" and "Physicians and Other Licensed Practitioner Services" account for 43.6% of the medical review projected dollars in error. Of the remaining 56.4% of the projected dollars in error, the top services are: Hospice Services; "Habilitation and Waiver Programs"; Personal Support Services; Prescribed Drugs; "Outpatient Hospital Services and Clinics"; and Inpatient Hospital.

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

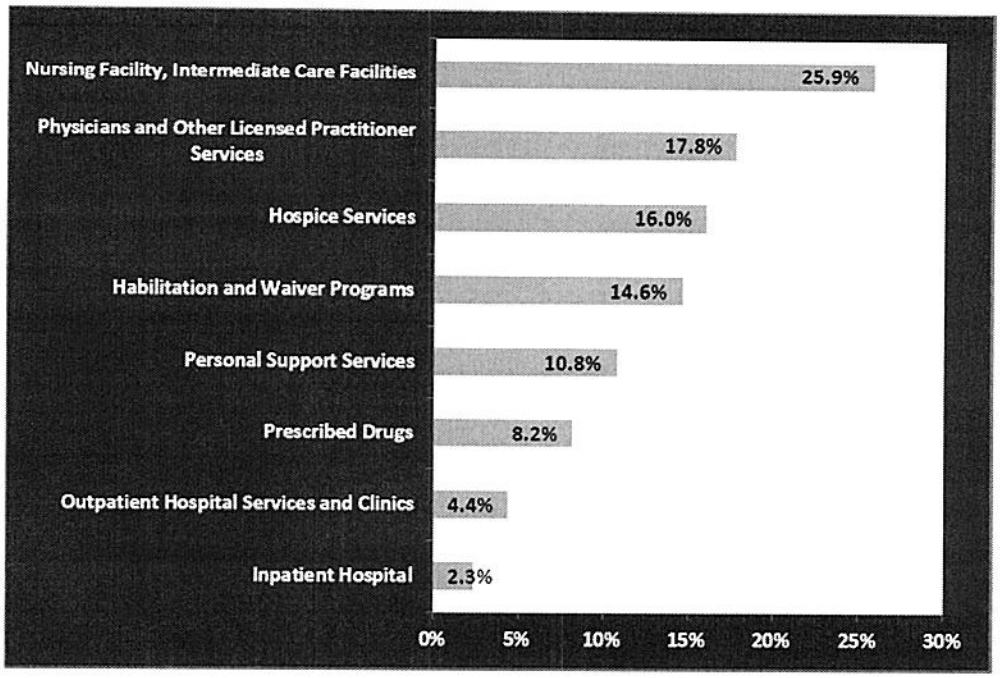


Table 4 has more information regarding the number of medical review errors and dollars in error for service types by overpayments, underpayments, and percentage of total medical review errors. The highest percentage of projected dollars in error arise from "Nursing Facility, Intermediate Care Facilities" at 25.9%, followed by "Physicians and Other Licensed Practitioner Services" at 17.8%, Hospice Services at 16.0%, "Habilitation and Waiver Programs" at 14.6%, Personal Support Services at 10.8%, and Prescribed Drugs at 8.2%.

Table 4: 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
Nursing Facility, Intermediate Care Facilities	4	$14,951	**$32,848,828**	0	$0	**$0**	22.2%	49.1%	**25.9%**
Physicians and Other Licensed Practitioner Services	3	$904	**$22,604,190**	0	$0	**$0**	16.7%	3.0%	**17.8%**
Hospice Services	3	$11,519	**$20,391,725**	0	$0	**$0**	16.7%	37.8%	**16.0%**
Habilitation and Waiver Programs	2	$327	**$18,611,917**	0	$0	**$0**	11.1%	1.1%	**14.6%**
Personal Support Services	2	$113	**$13,717,997**	0	$0	**$0**	11.1%	0.4%	**10.8%**
Prescribed Drugs	2	$901	**$10,372,949**	0	$0	**$0**	11.1%	3.0%	**8.2%**
Outpatient Hospital Services and Clinics	1	$305	**$5,568,611**	0	$0	**$0**	5.6%	1.0%	**4.4%**
Inpatient Hospital	1	$1,457	**$2,952,462**	0	$0	**$0**	5.6%	4.8%	**2.3%**
Total	18	$30,478	**$127,068,679**	0	$0	**$0**	100.0%	100.0%	**100.0%**

As shown in Table 5, the most projected dollars in error are due to Policy Violation from "Nursing Facility, Intermediate Care Facilities", followed by No Documentation for Hospice Services.

Table 5: Medicaid FFS Service Type by Medical Review Error Type in Projected Dollars

Service Type	Insufficient Documentation		Medically Unnecessary		No Documentation		Policy Violation		Procedure Coding Error	
	# of Error	Projected Dollars in Error	# of Error	Projected Dollars in Error	# of Error	Projected Dollars in Error	# of Error	Projected Dollars in Error	# of Error	Projected Dollars in Error
Habilitation and Waiver Programs	0	$0	0	$0	2	$18,611,917	0	$0	0	$0
Nursing Facility, Intermediate Care Facilities	1	$11,056,462	0	$0	0	$0	3	$21,792,366	0	$0
Outpatient Hospital Services and Clinics	1	$5,568,611	0	$0	0	$0	0	$0	0	$0
Physicians and Other Licensed Practitioner Services	0	$0	0	$0	2	$15,296,267	0	$0	1	$7,307,923
Hospice Services	0	$0	0	$0	3	$20,391,725	0	$0	0	$0
Inpatient Hospital	0	$0	1	$2,952,462	0	$0	0	$0	0	$0
Personal Support Services	0	$0	0	$0	2	$13,717,997	0	$0	0	$0
Prescribed Drugs	0	$0	0	$0	1	$6,130,088	1	$4,242,861	0	$0
Total	2	$16,625,073	1	$2,952,462	10	$74,147,994	4	$26,035,227	1	$7,307,923

Common Causes for Medicaid FFS Medical Review Errors by Service Type

Nursing Facility, Intermediate Care Facilities
- Policy Violation

Hospice Services
- No Documentation

Habilitation and Waiver Programs
- No Documentation

Physicians and Other Licensed Practitioner Services
- No Documentation

Personal Support Services
- No Documentation

2. Medicaid FFS Data Processing Review

The reason for Medicaid FFS data processing review errors in terms of projected dollars in error is Pricing Error.

Table 6 has more information regarding the number of FFS data processing review errors and dollars in error by overpayments, underpayments, and percentage of total FFS data processing review errors.

Table 6: 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
Pricing Error	2	$100	**$3,614,580**	1	$2	**$1,418,730**	100.0%	100.0%	**100.0%**
Total	2	$100	**$3,614,580**	1	$2	**$1,418,730**	100.0%	100.0%	**100.0%**

Common Causes for Medicaid FFS Data Processing Review Errors by Error Type

- A common cause is qualified by a cause that occurs more than once, thus there are no common causes listed.

As shown in Figure 5, the data processing dollars in error by service type can be attributed to "Outpatient Hospital Services and Clinics" and Prescribed Drugs. "Outpatient Hospital Services and Clinics" accounts for 71.5% of the projected dollars in error and Prescribed Drugs accounts for the remaining 28.5%.

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

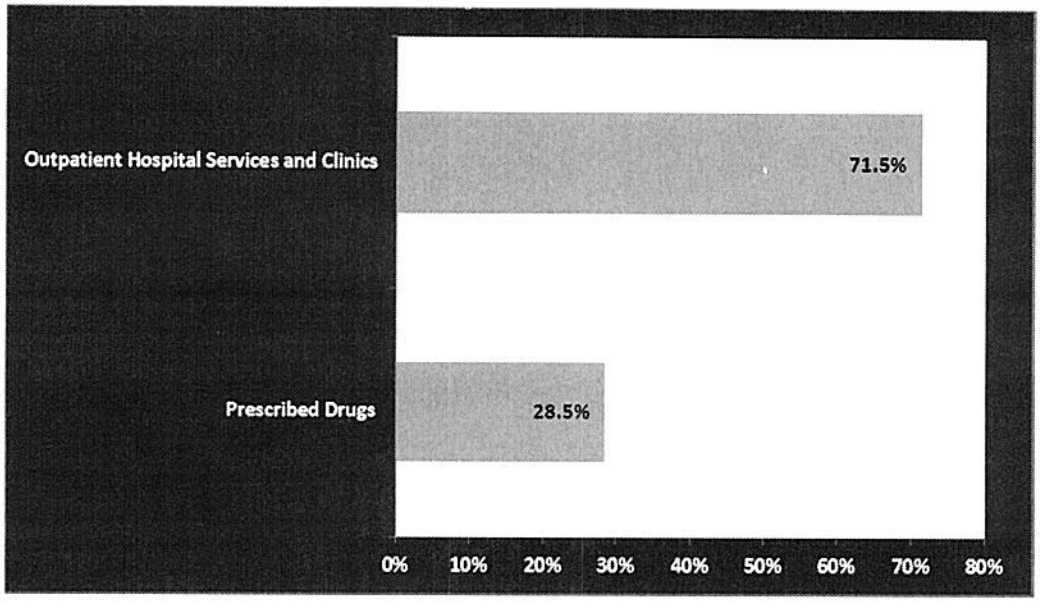


Table 7 shows that the greatest amount of projected dollars in error are due to Pricing Error from "Outpatient Hospital Services and Clinics", followed by Pricing Error for Prescribed Drugs.

Table 7: Medicaid FFS Service Type by Data Processing Review Error Type in Projected Dollars

Service Type	Pricing Error	
	# of Error	Projected Dollars in Error
Outpatient Hospital Services and Clinics	1	$3,597,454
Prescribed Drugs	2	$1,435,856
Total	3	$5,033,310

Common Causes for Medicaid FFS Data Processing Review Errors by Service Type

Prescribed Drugs

- Pricing Error

Medicaid Managed Care Data Analyses

There were no MC processing review errors in Louisiana, therefore there are no MC processing review findings.

Medicaid Eligibility Data Analyses

Our eligibility data analysis is limited as each State under the PERM program performed its own eligibility reviews and was only required to report eligibility and payment findings. The main source(s) of eligibility errors for Louisiana are:

- Not Eligible - Not Eligible means an individual beneficiary or family is receiving benefits under the program but does not meet the State's categorical and financial criteria being verified using the State's documented policy and procedures

Figure 6 shows the percentage of dollars in error by eligibility review error type for Louisiana. The eligibility errors were payments made where the findings were Not Eligible.

Figure 6: Medicaid Eligibility Review Percentages of Projected Dollars in Error by Error Type

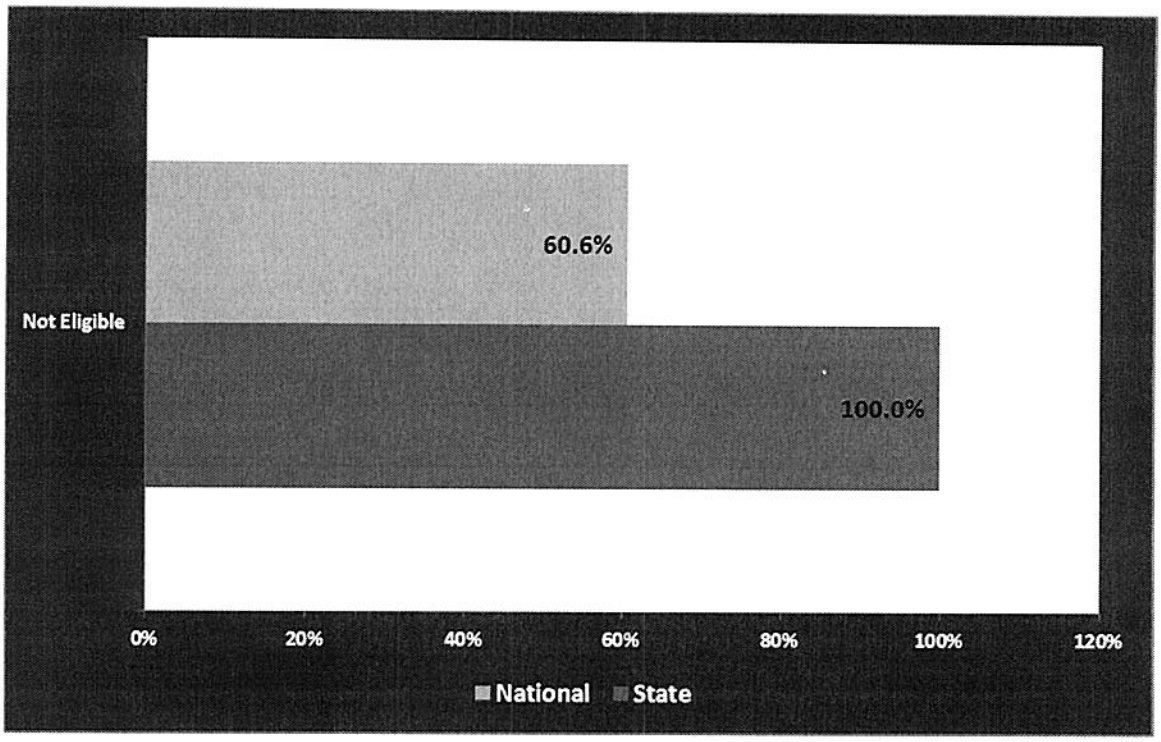


Table 8 shows Louisiana's Medicaid eligibility review findings for active cases by error type. The largest source of projected dollars in error for active cases was Not Eligible.

Table 8: Medicaid Eligibility Errors by Review Finding for Active Cases

Review Finding	# of Cases	% of Cases	Sample Dollars in Error	% of Dollars in Error	Projected Dollars in Error	% of Projected Dollars in Error
Not Eligible	1	100.0%	$115	100.0%	**$19,682,850**	100.0%
Total Active Cases	1	100.0%	$115	100.0%	**$19,682,850**	100.0%

Table 9 shows the number of Medicaid eligibility errors for active cases, comparing the number of errors and projected dollars in error by case action. The projected dollars in error arise from the Redetermination case action.

Table 9: Medicaid Eligibility Errors for Active Cases by Case Action by Number of Errors and Projected Dollars in Error

Case Action	# of Errors	% of Errors	Dollars in Error	% of Dollars in Error	Projected Dollars in Error	% of Projected Dollars in Error
Redetermination	1	100.0%	$115	100.0%	**$19,682,850**	100.0%
Total Active Cases	1	100.0%	$115	100.0%	**$19,682,850**	100.0%

For the negative case review, no errors were found in the sample.

F. Deficiencies

Although not considered payment errors, some deficiencies were noted during review of the PERM claims sample. A deficiency is generally defined as an action or inaction on the part of the State or the provider that could have resulted in a dollar error but did not. For example, for data processing, a male was coded as a female in the MMIS system but because the service provided could have been appropriate for either sex, it did not result in a dollar difference. For medical review, a typical example is a provider who billed for the wrong procedure code; however, the correct procedure code would have paid the same rate per unit. Therefore, it did not result in a dollar difference, but could have under other circumstances. These are enumerated for your consideration in this section.

Table 10 lists the data processing deficiencies found in Louisiana as well as the medical review deficiencies.

Table 10: Medicaid Deficiencies Noted During PERM Claims Review

Review Type	# of Deficiencies	% of Deficiencies
Data Processing Deficiencies	1	33.3%
Medical Review Deficiencies	2	66.7%
Total Deficiencies	3	100.0%

The reasons for these findings are noted below.

Data Processing Deficiencies

- Problem noted with claim but no financial impact

Medical Review Deficiencies

- DOS incorrect but within 7 days of claim

G. Types of Payment Errors

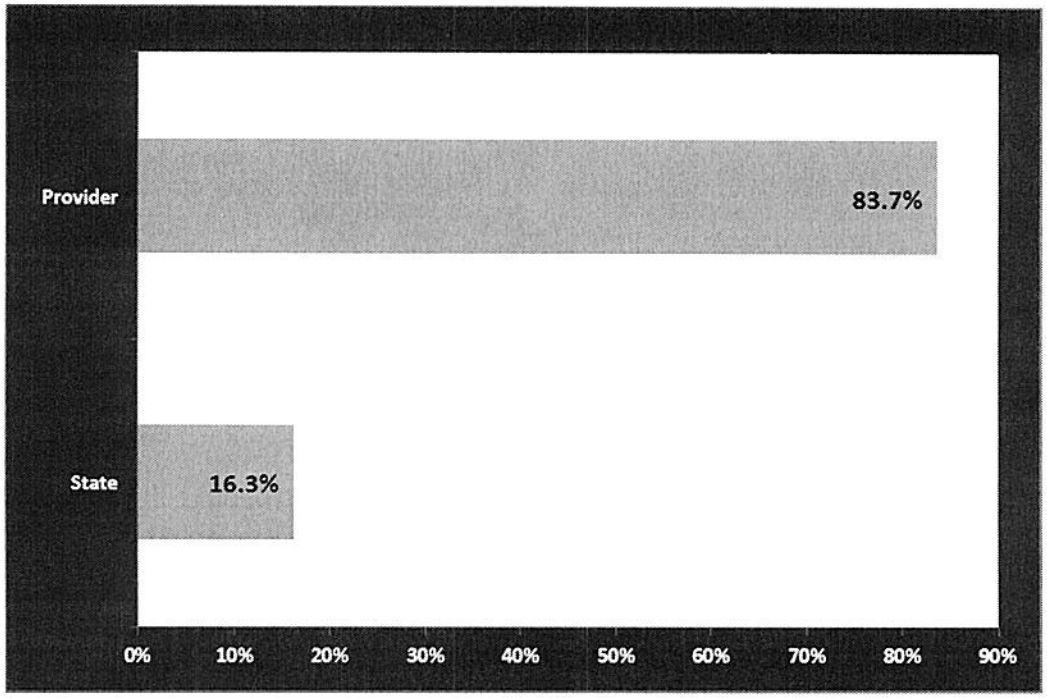
The PERM Final Rule allows for classifying data processing errors and eligibility review errors as State errors and medical review errors as provider errors. This section analyzes Louisiana payment errors for FY 2011 in light of this classification. Table 11 shows how the errors aggregate into these two types of payment errors.

Table 11: Medicaid Types of Payment Errors

Error Type	# of Errors	% of Total # of Errors	Sample Amount in Error	% of Sample Dollars in Error	Projected Dollars in Error	% of Projected Dollars in Error	State or Provider Error
Medical Review Errors	18	81.8%	$30,478	99.3%	**$127,068,679**	83.7%	Provider
Data Processing Errors	3	13.6%	$102	0.3%	**$5,033,310**	3.3%	State
Eligibility Errors	1	4.5%	$115	0.4%	**$19,682,850**	13.0%	State

Figure 7 shows the percentage of State versus provider errors by projected dollars in error. In Louisiana, State errors account for 16% of projected dollars in error, while provider errors comprise 84%.

Figure 7: Medicaid Types of Payment Errors



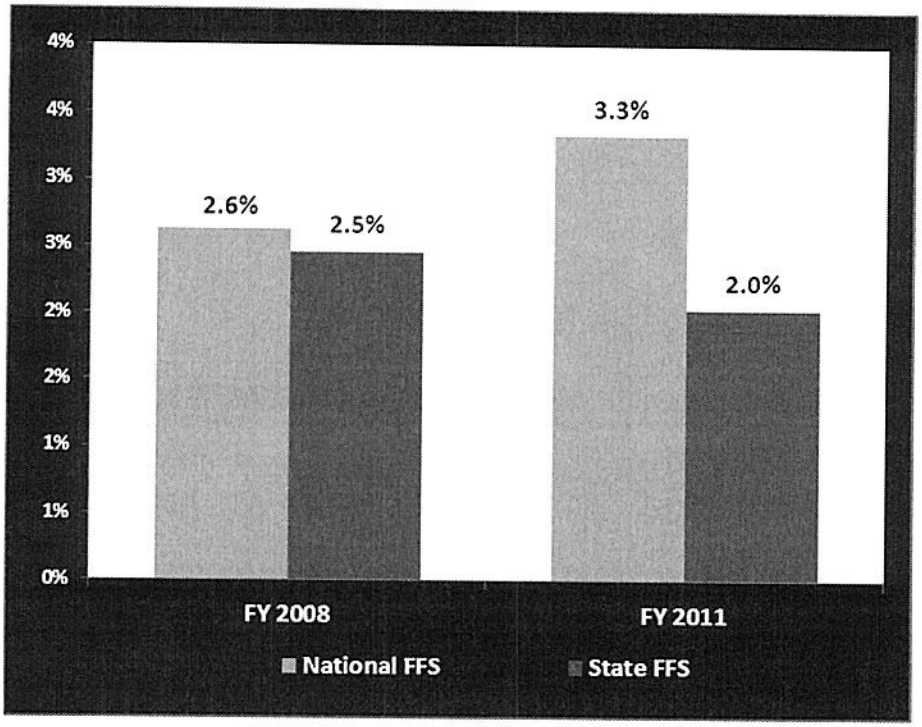
H. Comparison of Medicaid FY 2008 and FY 2011

This section provides a brief comparison of the sample findings for Louisiana in FY 2008 and FY 2011 for Medicaid.

Louisiana's Medicaid FFS Findings

Figure 8 compares the nation and Louisiana for FY 2008 and FY 2011. Louisiana's Medicaid FFS error rate was 2.5% in FY 2008 as compared to 2.0% for the FY 2011 measurement. In both measurement cycles Louisiana's error rate was below the national average.

Figure 8: National and State Medicaid FFS Error Rates



Sample Medicaid FFS Comparisons

Table 12 summarizes the total number of errors found for Medicaid FFS in FY 2008 and FY 2011 for Louisiana.

Table 12: Comparison of Medicaid FFS Number of Errors*

Fiscal Year	Number of Errors
FY 2008	7
FY 2011	21

*If both medical review and data processing errors are found for the same claim it only appears as one error in this count

Table 13 compares Louisiana's errors in FY 2011 to the number of errors found in the FY 2008 sample by Error Type. More errors were found in FY 2011 as compared to FY 2008.

Table 13: Medicaid FFS FY 2008 and FY 2011 Number of Errors by Type of Error

	Number of Errors In Sample	
	FY 2008	FY 2011
Medical Review Errors		
No Documentation	0	10
Insufficient Documentation	2	2

Procedure Coding Error	1	1
Diagnosis Coding Error	0	0
Unbundling	0	0
Number of Unit(s) Error	0	0
Medically Unnecessary	2	1
Policy Violation	0	4
Admin/Other	0	0
Total	**5**	**18**
Data Processing Errors		
Duplicate Item	0	0
Non-covered Service	1	0
FFS Claim for Managed Care Service	0	0
Third-party Liability	0	0
Pricing Error	0	3
Logic Edit	0	0
Data Entry Error	1	0
Rate Cell Error	0	0
Managed Care Payment Error	0	0
Admin/Other	0	0
Total	**2**	**3**

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

Table 14: Medicaid FFS FY 2008 and FY 2011 Number of Errors by Service Type

Service Type	FY 2008	FY 2011
Inpatient Hospital	3	1
Psychiatric, Mental Health, and Behavioral Health Services	0	0
Nursing Facility, Intermediate Care Facilities	1	4
ICF for the Mentally Retarded and Group Homes	2	0
Outpatient Hospital Services and Clinics	0	2
Physicians and Other Licensed Practitioner Services	0	3
Dental and Other Oral Surgery Services	0	0
Prescribed Drugs	0	4
Home Health Services	0	0
Personal Support Services	0	2
Hospice Services	0	3
Therapies, Hearing and Rehabilitation Services	0	0
Habilitation and Waiver Programs	0	2
Laboratory, X-ray and Imaging Services	0	0

Vision: Ophthalmology, Optometry and Optical Services	0	0
Durable Medical Equipment (DME) and supplies, Prosthetic/Orthopedic devices and Environmental Modifications	1	0
Transportation and Accommodations	0	0
Denied Claims	0	0
Crossover Claims	0	0
Capitated Care/Fixed Payments	0	0
Managed Care	0	0
Unknown	0	0
Overall Medicaid FFS	**7**	**21**

Sample Medicaid Managed Care Comparisons

There is no MC program in Louisiana; therefore there are no MC comparison findings.

Sample Medicaid Eligibility Review Comparisons

Figure 10 compares the nation and Louisiana for FY 2008 and FY 2011. Louisiana's Medicaid Eligibility error rate was 1.5% in FY 2008 as compared to 0.3% for the FY 2011 measurement. In both measurement cycles Louisiana's error rate was below the national average.

Figure 10: National and State Medicaid Eligibility Error Rates

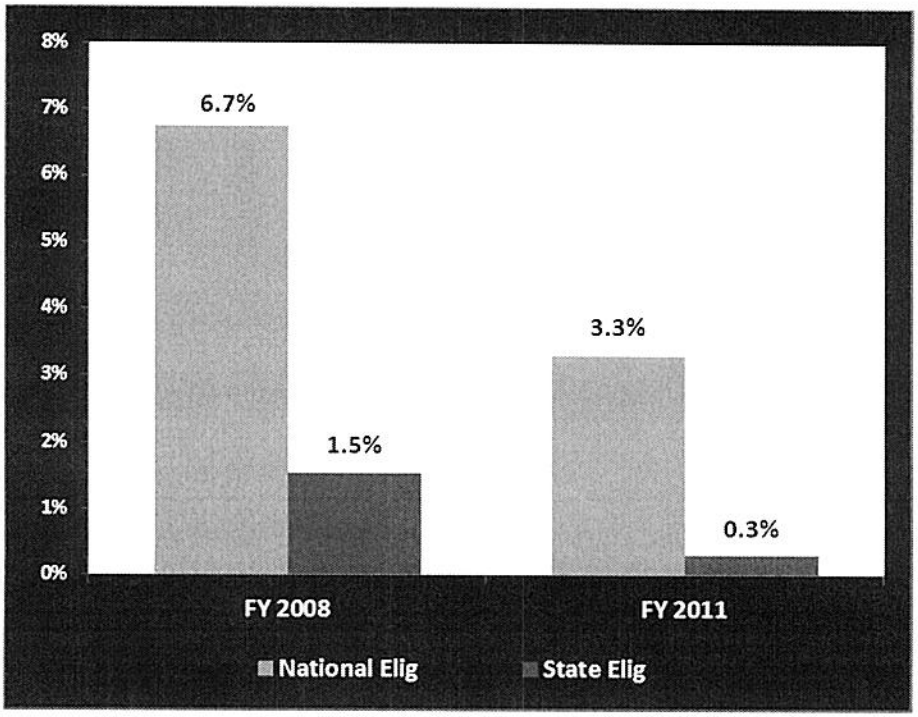


Table 15 and Table 16 compare the Eligibility Error Findings for FY 2008 and FY 2011 for Active and Negative Cases.

Table 15: Medicaid Eligibility Error Findings for FY 2008 and FY 2011

Review Finding	Active Cases Total Number of Errors		Negative Cases Total Number of Errors	
	FY 2008	FY 2011	FY 2008	FY 2011
Not Eligible	28	1	0	0
Eligible with Ineligible Services	1	0	0	0
Undetermined	1	0	0	0
Liability Understated	4	0	0	0
Liability Overstated	0	0	0	0
Managed Care Error, Ineligible for Managed Care	0	0	0	0
Managed Care Error, Eligible for Managed Care but Improperly Enrolled	0	0	0	0
Improper Denial	0	0	0	0
Improper Termination	0	0	1	0
Total Cases	**34**	**1**	**1**	**0**

Table 16: Medicaid Eligibility Error Findings by Stratum

Stratum	FY 2008	FY 2011
Application	9	0
Redetermination	17	1
All Other Active Cases	8	0
Active Cases	**34**	**1**

I. HCBS Supplemental Measure

Louisiana had 30 Home and Community Based Services (HCBS) claims reviewed for this supplemental measure. Of the $10,289 sample payments, $0 was found to be in error.

Medical Review

There were no HCBS medical review errors identified for the State of Louisiana.

Data Processing Review

There were no HCBS processing review errors identified for the State of Louisiana.

Conclusion

Louisiana has a low overall Medicaid error rate compared to the States measured in FY 2011, with the third lowest error rate of the 17 Cycle 3 States. The FFS component was the most

problematic, with an estimated error rate of 2.0%. The FFS medical record review improper payments were largely due to No Documentation, Policy Violation, and Insufficient Documentation. These errors were further clustered primarily within the following service types: "Nursing Facility, Intermediate Care Facilities", Hospice Services, and "Habilitation and Waiver Programs". Within the FFS data processing review, improper payments were mainly associated with Pricing Error. For eligibility, the largest sources of projected dollars in error are due to Not Eligible.

Louisiana Cycle Summary Report Addendum for Medicaid Findings

This addendum to the Cycle Summary Report provides more detail for the State of Louisiana regarding the cause of each error identified in the Medicaid PERM sample. Error causes are classified as individual errors, error trends (when more than one error was identified for the same root cause) and deficiencies (when no impact on payment was determined). This analysis of error causes is presented for three components of the PERM sample: Data Processing FFS Errors, Managed Care Errors and Medical Review FFS Errors by error code and claim category (provider type).

Louisiana Medicaid Data Processing Errors/Error Trends

Only three data processing errors and one deficiency are cited for Louisiana's FFS Medicaid program, however, all are separate issues with no trends within the Medicaid PERM sample noted.

- Error (1) - $96.61 overpayment – System input error caused incorrect pricing – Incorrect provider ratio was entered into the provider-specific rate file. Keying error was not corrected within the 60 day timeframe for PERM.
- Error (1) - $3.00 overpayment – Co-pay should have been deducted from payment – A co-pay was not deducted from claim and State was unable to locate a policy that exempted this category of recipient from the co-pay requirement.
- Error (1) - $2.00 underpayment – Co-pay should not have been deducted from claim - LA requires providers to enter a code on the claim to indicate the recipient is exempt from a co-pay, however Federal requirements do not allow co-pays to be collected from pregnancy related services or prescriptions. Since the co-pay was deducted from a pregnancy related claim, an underpayment was cited. Note: the same issue was cited in the CHIP sample.
- Deficiency (1) – zero dollar impact – Logic edit issue – a flag for Error code 774 was not reset properly however, it did not impact the selected line for this emergency room claim. Had another line been sampled this could have resulted in an error.

Louisiana Medicaid Managed Care Errors/Trends

There are no errors identified for Medicaid Managed Care for Louisiana in FY 2011 Cycle

Louisiana Medicaid Medical Review (MR) Errors/Trends

Analysis By Medical Review Error Code:

The total Medical Review Errors for Louisiana's Medicaid Sample is 20. This is the fourth highest number of errors this cycle. Medical Review errors are spread across six error types with three possible trends identified. The type of Error Codes and Error Causes are the following:

- MR1 Errors (10) – No documentation submitted within required timeframes equals 50% of total MR errors for Louisiana Medicaid, compared to a cycle rate of 20%. One provider was out of business and no record is available, five providers did not respond within the allowed timeframe, one provider cannot locate the record, three providers submitted records after the cutoff date.
- MR2 Errors (2) – Insufficient documentation to support the claim equals 10% of total MR errors for Louisiana Medicaid, compared to a cycle rate of 33%. Two providers did not supply sufficient documentation to support the claims: one provider did not submit a physician progress note for the Nursing Facility visit sampled and one provider did not submit physician orders, medication administration records or itemized list for 240 units of HR636.
- MR3 Error (1) – Wrong procedure code billed equals 5% of total MR errors for Louisiana Medicaid, compared to a cycle rate of 1.4%. This provider billed procedure code 99479 for evaluation and management of recovering low birth weight but should have billed for procedure code 99480 (based on infant's current weight).
- MR7 Error (1) – Medically unnecessary services equals 5% of total MR errors for Louisiana Medicaid, compared to a cycle rate of .5%. Patient could have been treated at a lower level of care and did not require hospitalization (dizziness due to OTC medication).
- MR8 Errors (4) – Policy Violation errors equals 20% of total MR Errors for Louisiana Medicaid, compared to a cycle rate of 15%. Three of these errors are on Nursing Facility claims caused by one patient's physician orders were not signed, one provider could not locate the physician progress note for the month sampled and the third provider did not have timely physician progress notes completed within 60 day visit time period. The fourth error is for a pharmacy claim where the prescription was not signed by the prescriber.
- MTD (2) – Medical technical deficiency without impact on error rate equals 10% of the total MR Errors for Louisiana Medicaid, compared to a cycle rate of 6%. For both errors, there are date of service billing errors from two different providers but within 7 days of paid date so there is no financial impact. One is for procedure code D5140 and the second is for procedure code 99220.

Analysis By Claim Category (Provider Type):

Medical Review Errors (20) are identified in nine claim categories (provider types) with three possible trends identified. Error codes and error causes for all Medical Review Errors for Medicaid by Claim Categories are:

- Category 1 – Hospital Services (1) – One error for medically unnecessary care is identified for a hospitalization that was unnecessary and patient could have been treated at a lower level of care. Louisiana represents 6% of the total Cycle errors in this category.

- Category 3 – Nursing Facility Services (4) – One error is an MR2 error for insufficient documentation due to no progress note submitted for visit sampled, and three are MR8 errors for policy violation – two of which are for physician orders not signed and another for no timely 60 day visit or progress note by physician. The third MR8 error is due to no prescriber's signature on prescription filled. Louisiana represents 16% of the total Cycle errors in this category.
- Category 5 - Outpatient Services (1) – The one error for this category is for MR2 error for insufficient documentation to support the claim since no physician orders or medication administration records are available. Louisiana represents 9% of the total Cycle errors in this category.
- Category 6 – Physician Services (4) – There are two MR1 errors for no documentation submitted to support the claim, one MR3 error for wrong procedure code billed involving code 99479 that should have been billed as 99480 and one MTD for a date of service billing error without financial impact. Louisiana represents 20% of the total Cycle errors in this category.
- Category 7 – Dental and Oral Surgery Services (1) – The one error for this category is for MTD where there is a date of service billing error with no financial impact on the error rate. Louisiana represents 7% of the total Cycle errors in this category.
- Category 8 – Pharmacy Services (2) – There are two errors for this category; one for MR1 no documentation submitted within required timeframes and one for MR8 Policy Violation for prescription filled without prescriber's signature. Louisiana represents 8% of the total Cycle errors in this category.
- Category 10 – Personal Support Services (2) – There are two errors for this category for MR1 No Documentation submitted within allowed timeframes. Louisiana represents 6% of the total Cycle errors in this category.
- Category 11 – Hospice Services (3)– There are three MR1 errors for this category for no documentation submitted within allowed timeframes. Louisiana represents 75% of the total Cycle errors in this category.
- Category 13 – Day Habilitation and Waiver Services (2) – There are two errors for MR1 no documentation submitted within required timeframe in this category. Louisiana represents 6% of the total Cycle errors in this category.