INSTRUCTIONS FOR COMPLETING THE PERM ELIGIBILITY REVIEWS:
DETAILED PAYMENT REVIEW FINDINGS

Purpose: The Detailed Payment Review Findings form provides detailed payment review findings for all cases in each monthly
sample. This form identifies the total dollars paid, the amount correctly paid and the amount paid in error for each case, as
appropriate, in the sample for a given month.
This form is due 210 days from the end of the sample month (i.e., the payment review for the sample month of January is due
on August 31, which is 210 days from January 31).

Line by Line Instructions

Line A: State
Enter the name of the State participating in the PERM program that is submitting this report. "State" refers to the 50 States and
the District of Columbia. The Territories are excluded from the PERM program.

Line B: Date
Enter the date that the Detailed Payment Review form is being submitted to CMS (e.g., June 15, 2007).

Line C: Program
Enter the program for which the Detailed Payment form applies (e.g., Medicaid or SCHIP).

Line D: Sample Month and Year
Enter the month and year for which the sample was drawn from the universe. "Universe" refers to the total number of cases in the sample month. The case universe will be unique for each month.

Line E: Case/ Beneficiary ID
"Case" refers to an individual beneficiary and, for PERM purposes, is not a household or family unit. In this row, enter the case
ID or beneficiary ID, whichever is the custom of the State, which correlates with the case reported as sampled on the monthly
sample selection list for the sample month.

Add rows if the number of cases in the active case sample for the month being reported exceeds the number of rows provided.

Note: Include all sampled cases in this table, not just those with payment errors.

Dropped Due to Beneficiary Fraud

"Active beneficiary fraud investigation" is defined as a beneficiary's name has been referred to the State Fraud and Abuse Control or similar investigation unit and the unit is currently and actively pursuing an investigation to determine whether the beneficiary committed fraud.

- States should exclude cases under active beneficiary fraud investigation from the universe. However, if a State cannot
  exclude these cases from the universe, the State can drop these cases if they appear in the sample.
- If a case was dropped from the sample due to an active beneficiary fraud investigation, enter the date the case was
  dropped (e.g., 6/15/07). If the case was not dropped, leave this column blank.

Stratum
Enter the number of the eligibility stratum for the case (e.g., Stratum 1). The strata are as follows:

Stratum 1–Applications: A case constitutes an "application" for the sampling month if the State took an action to grant
eligibility in that month based on a completed application.

FORM CMS-10184D (01/07) EF (02/2007)
Stratum 2–Redeterminations: A case constitutes a "redetermination" for the sampling month if the State took an
action to continue eligibility in the sample month based on a completed redetermination.

Stratum 3–All Other Cases: All other cases (properly included in the universe but do not meet the strata one or two
criteria) that are on the program in the sample month are placed in stratum three.

Review Finding
Enter the letter code for the review finding (e.g., MCE1) for each case. The eight review findings are defined as follows:

E–Eligible: An individual beneficiary meets the State's categorical and financial criteria for receipt of benefits under
the program.

EI–Eligible with ineligible services: An individual beneficiary meets the State's categorical and financial criteria
for receipt of benefits under the Medicaid or SCHIP programs but was not eligible to receive particular services. An
example of "eligible with ineligible services" would be a case where the beneficiary did not fully pay his share of cost.
Another example would be a person eligible under the medically needy group who received services not provided to
the medically needy group.

NE–Not eligible: An individual beneficiary is receiving benefits under the program but does not meet the State's
categorical and financial criteria for the month eligibility is being verified.

U–Undetermined: A beneficiary case subject to a Medicaid or SCHIP eligibility determination under PERM about
which a definitive determination of eligibility could not be made.

L/O–Liability overstated: The beneficiary paid too much toward his liability amount or cost of institutional care and the
State paid too little.

L/U–Liability understated: Beneficiary paid too little toward his liability amount or cost of institutional care and the
State paid too much.

MCE1–Managed care error, ineligible for managed care: Upon verification of residency and program eligibility, and
the beneficiary is enrolled in managed care but is not eligible for managed care.

MCE2–Managed care error, eligible for managed care but improperly enrolled: Beneficiary is eligible for both the
program and for managed care but not enrolled in the correct managed care plan as of the month eligibility is being
verified.

Payment Amount Correct – A correct payment amount is a payment to a provider, insurer, or managed care
organization based on the beneficiary's eligibility for the program and for the services received under the coverage group
under which the beneficiary is eligible as defined in the State's plan.

- For FFS cases, enter the total amount of dollars paid for the beneficiary based on claims for services rendered at any
  time in the spend down period (if appropriate) through the review month or are rendered in the sample month (for
  cases in stratum 3) which are paid by the end of the fourth month after the review month (or sample month for cases in
  stratum 3).
- For managed care cases, enter the capitated amount paid for the case. All managed care payments made for coverage
  in the review month (for strata 1 and 2 cases) and the sample month (for stratum 3 cases) are included regardless
  of the actual payment date so long as the payment dates fall within the review month (for cases in strata 1 and 2) or
  sample month and are paid by the end of the fourth month after the review month or sample month.

Enter the portion of the payments, in part or in whole as appropriate, that were correct for each sampled case. Do not enter payment amounts for cases that are dropped due to beneficiary fraud.

- **Payment Amount in Error –** Enter the amount of payment that is in error based on the beneficiary's:
- ineligibility for services received,
- ineligibility for the program,
- liability overstated or understated,
- ineligibility for managed care, or
- eligibility for managed care but enrollment in the wrong managed care plan.

Enter the portion of the payment, in whole or in part, that was in error for each sampled case.

Payment Error Rate Measurement (PERM) Eligibility Reviews:

Detailed Payment Review Findings

Due within 210 days of the end of each sample month.

A. State	
B. Date	
C. Program	
D. Sample Month & Year	

E. Case ID	Dropped Due to Beneficiary Fraud	Stratum 1,2 or 3	Review Finding	Payment Amount Correct	Payment Amount in Error	Amount Undetermined
			E-eligible EI-eligible with ineligible services NE-not eligible U-undetermined L/O-liability overstated L/U-understated MCE1-managed care error, ineligible for managed care MCE2-eligible for managed care but improperly enrolled			
1						
2						
3						
4						
5						
6						
7						
8						

9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						