



Osnabrock Community Living Center  
326 Rainbow Road  
Osnabrock, ND 58269

**Billing Provider ID: 1417297888**

**Payee ID: 11394805**

**Payment Error Rate Measurement (PERM) RY (Review Year) 2022**

The PERM program measures improper payments in Medicaid and the Childrens Health Insurance Program (CHIP) and produces error rates for each program. The error rates for RY2022 will be based on reviews of fee-for-service (FFS), managed care, and eligibility components for Medicaid and CHIP based on a random sample of claims with paid dates from 07/01/2020 to 06/30/2021.

It is important to note the error rate is not a ?fraud rate? but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements.

The review contractor, NCI Information Systems (NCI), has started sending letters to various Medicaid providers requesting medical records to validate that the service was ordered, provided, documented and billed appropriately.

Please make sure that your Release of Information departments are aware and responding to the records requests in a timely manner.

NCI started sending medical record request letters to providers on May 17, 2021; record requests will go through April 2022.

Failure to submit documentation, or if the submitted documentation is incomplete, the claim will be considered an error and subject to recoupment.

When submitting records, you are required to use the corresponding medical review (MR) cover sheet with each submission for quick and accurate processing of record submissions. The MR cover sheet is included with your PERM letter packet



000000000

Payee ID: 11394805

Remittance No: 589499

EFT/Check Number: 3284405

Payment Date: 10/12/2021

## PAID

## Long Term Care

TCN	Member ID	Member Name	CFI	Patient Account Number	Billed Amt	Paid Amt
21278100070000380	ND4729315	BROWER FLOYD		02	\$3,300.00	\$2,795.18

Remark Codes M143|N257

LNN	From Date	Thru Date	MDS	Rev	Proc/Mod	Billed Units/Days	Billed Amt	Paid Amt	Status
1	09/01/2021	09/30/2021		0167		30.0	\$2,163.90	\$1,701.00	P

## Adjustment Reasons: Adjustment Group Code | Adjustment Reason Code | Adjustment Amount

PR | 142 | \$462.90

2	09/01/2021	09/30/2021		0110		30.0	\$1,136.10	\$1,094.18	P
---	------------	------------	--	------	--	------	------------	------------	---

## Adjustment Reasons: Adjustment Group Code | Adjustment Reason Code | Adjustment Amount

PR | 142 | \$41.92

TCN	Member ID	Member Name	CFI	Patient Account Number	Billed Amt	Paid Amt
21278100070000390	ND3120850	DUERR RAY		04	\$3,300.00	\$2,586.00

Remark Codes M143|N257

LNN	From Date	Thru Date	MDS	Rev	Proc/Mod	Billed Units/Days	Billed Amt	Paid Amt	Status
1	09/01/2021	09/30/2021		0167		30.0	\$2,163.90	\$2,163.90	P
2	09/01/2021	09/30/2021		0110		30.0	\$1,136.10	\$422.10	P

## Adjustment Reasons: Adjustment Group Code | Adjustment Reason Code | Adjustment Amount

PR | 142 | \$714.00

TCN	Member ID	Member Name	CFI	Patient Account Number	Billed Amt	Paid Amt
21278100070000330	ND3046672	KROHN ALICE		01	\$3,300.00	\$2,593.26

Remark Codes M143|N257

<b>Payee ID: 11394805</b>	<b>Remittance No: 589499</b>	<b>EFT/Check Number: 3284405</b>	<b>Payment Date: 10/12/2021</b>
---------------------------	------------------------------	----------------------------------	---------------------------------

LNN	From Date	Thru Date	MDS	Rev	Proc/Mod	Billed Units/Days	Billed Amt	Paid Amt	Status
1	09/01/2021	09/30/2021		0167		30.0	\$2,163.90	\$2,163.90	P
2	09/01/2021	09/30/2021		0110		30.0	\$1,136.10	\$429.36	P

<b>Adjustment Reasons:</b>	<b>Adjustment Group Code   Adjustment Reason Code   Adjustment Amount</b>
	PR   142   \$706.74

TCN	Member ID	Member Name	CFI	Patient Account Number	Billed Amt	Paid Amt
21278100070000400	ND3414745	MELING LILLIAN		05	\$3,300.00	\$2,384.50

<b>Remark Codes</b>	M143 N257
---------------------	-----------

LNN	From Date	Thru Date	MDS	Rev	Proc/Mod	Billed Units/Days	Billed Amt	Paid Amt	Status
1	09/01/2021	09/30/2021		0167		30.0	\$2,163.90	\$2,059.40	P

<b>Adjustment Reasons:</b>	<b>Adjustment Group Code   Adjustment Reason Code   Adjustment Amount</b>
	PR   142   \$104.50

2	09/01/2021	09/30/2021		0110		30.0	\$1,136.10	\$325.10	P
---	------------	------------	--	------	--	------	------------	----------	---

<b>Adjustment Reasons:</b>	<b>Adjustment Group Code   Adjustment Reason Code   Adjustment Amount</b>
	PR   142   \$811.00

TCN	Member ID	Member Name	CFI	Patient Account Number	Billed Amt	Paid Amt
21278100070000410	ND3443257	SPENST DONALD		06	\$3,300.00	\$2,544.08

<b>Remark Codes</b>	M143 N257
---------------------	-----------

LNN	From Date	Thru Date	MDS	Rev	Proc/Mod	Billed Units/Days	Billed Amt	Paid Amt	Status
1	09/01/2021	09/30/2021		0167		30.0	\$2,163.90	\$2,163.90	P
2	09/01/2021	09/30/2021		0110		30.0	\$1,136.10	\$380.18	P

<b>Adjustment Reasons:</b>	<b>Adjustment Group Code   Adjustment Reason Code   Adjustment Amount</b>
	PR   142   \$755.92

<b>Total Long Term Care Claim Total: 5</b>	<b>Mcaid Alwd: \$16,500.00</b>	<b>Paid Amt: \$12,903.02</b>
--	--------------------------------	------------------------------

Payee ID: 11394805

Remittance No: 589499

EFT/Check Number: 3284405

Payment Date: 10/12/2021

**DENIED****Long Term Care**

TCN	Member ID	Member Name	CFI	Patient Account Number	Billed Amt	Paid Amt
21278100070000430	ND3146354	STECKLER MARY		03	\$14.00	\$0.00

**Remark Codes** M54|MA30|MA43|N146|M143|N257

LNN	From Date	Thru Date	MDS	Rev	Proc/Mod	Billed Units/Days	Billed Amt	Paid Amt	Status
1	09/01/2021	09/14/2021		0167		14.0	\$1,009.82	\$0.00	D

**Adjustment Reasons:** Adjustment Group Code | Adjustment Reason Code | Adjustment Amount

CO | 16 | \$1,009.82

2	09/01/2021	09/14/2021		0110		14.0	\$530.18	\$0.00	D
---	------------	------------	--	------	--	------	----------	--------	---

**Adjustment Reasons:** Adjustment Group Code | Adjustment Reason Code | Adjustment Amount

CO | 16 | \$530.18

TCN	Member ID	Member Name	CFI	Patient Account Number	Billed Amt	Paid Amt
21278100070000440	ND3146354	STECKLER MARY		03	\$1,540.00	\$0.00

**Remark Codes** N146|M143|N257

LNN	From Date	Thru Date	MDS	Rev	Proc/Mod	Billed Units/Days	Billed Amt	Paid Amt	Status
1	09/01/2021	09/01/2021		0167		14.0	\$1,009.82	\$0.00	D

**Adjustment Reasons:** Adjustment Group Code | Adjustment Reason Code | Adjustment Amount

CO | 16 | \$1,009.82

2	09/01/2021	09/14/2021		0110		14.0	\$530.18	\$0.00	D
---	------------	------------	--	------	--	------	----------	--------	---

**Adjustment Reasons:** Adjustment Group Code | Adjustment Reason Code | Adjustment Amount

CO | 16 | \$530.18

<b>Total Long Term Care Claim Total: 2</b>			<b>Mcaid Alwd: \$0.00</b>			<b>Paid Amt: \$0.00</b>			
--	--	--	---------------------------	--	--	-------------------------	--	--	--

**Payee ID: 11394805****Remittance No: 589499****EFT/Check Number: 3284405****Payment Date: 10/12/2021****GRAND TOTALS - SUMMARY**

	<b>Total Number of Claims Paid</b>	<b>Total Amount Paid</b>	<b>Total Number of Claims Voided</b>	<b>Total Amount Voided</b>	<b>Total Number of Claims Denied</b>	<b>Total Amount Denied</b>
<b>Long Term Care</b>	5	\$12,903.02	0	\$0.00	2	\$0.00
<b>Grand Total</b>	5	\$12,903.02	0	\$0.00	2	\$0.00

<b>In Process</b>	<b>Total Number of Transactions: 0</b>	<b>Total Amount: \$0.00</b>
<b>Fiscal Pend</b>	<b>Total Number of Transactions: 0</b>	<b>Total Amount: \$0.00</b>
<b>Total Payment Amount</b>	<b>Total Number of Transactions: 7</b>	<b>Total Payment Amount: \$12,903.02</b>

**Payee ID: 11394805****Remittance No: 589499****EFT/Check Number: 3284405****Payment Date: 10/12/2021****Calendar Year to Date Summary**

	<b>Total Number of Claims</b>	<b>Total Amount</b>
<b>Paid</b>	62	\$131,649.15
<b>Denied</b>	10	\$0.00
<b>In Process</b>	1	\$600.00
<b>1099 Amount</b>	62	\$131,649.15
<b>Unreported 1099 Amount</b>	0	\$0.00
<b>Payouts</b>	0	\$0.00

**Payee ID: 11394805**

**Remittance No: 589499**

**EFT/Check Number: 3284405**

**Payment Date: 10/12/2021**

**Adjustment Group Code**

**Description**

**CO**

Contractual Obligations

**PR**

Patient Responsibility

**Payee ID: 11394805****Remittance No: 589499****EFT/Check Number: 3284405****Payment Date: 10/12/2021**

<b>Adjustment Reason Code</b>	<b>Description</b>
<b>142</b>	Monthly Medicaid patient liability amount.
<b>16</b>	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s) /other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
<b>Remark Code</b>	<b>Description</b>
<b>M143</b>	The provider must update license information with the payer.
<b>M54</b>	Missing/incomplete/invalid total charges.
<b>MA30</b>	Missing/incomplete/invalid type of bill.
<b>MA43</b>	Missing/incomplete/invalid patient status.
<b>N146</b>	Missing screening document.
<b>N257</b>	Missing/incomplete/invalid billing provider/supplier primary identifier.