Payment Error Rate Measurement Program
CMS PERM Review Contractor,
NCI Information Systems, Inc.
8701 Park Central Drive, Suite 400 B
Richmond, VA 23227

[||ProviderName||]
ATTN: [||ContactName||], [||ContactTitle||]
[||ContactAddress1||] [||ContactAddress2||]
[||ContactCity||], [||ContactState||] [||ContactZipcode||]

Date: [||RequestDate||]
Reference ID: [||PERM ID||]
OMB Control Number: [||OMB#||]
NPI: [||NPI#||]

Request Type & Purpose: Additional Documentation Request (First Additional Documentation Request)
Subject: Additional Documentation – This is not a duplicate request

To request a copy of this letter in Spanish, please contact the PERM Customer Service Department at 800-393-3068. Once a Spanish-language letter is requested, all future correspondence for this specific PERM ID will continue in Spanish.

Para solicitar una copia de esta carta en Español, por favor de contactar al Departamento de Servicio al Cliente de PERM al 800-393-3068. Una vez que la carta en Español sea solicitada, toda correspondencia futura especifica a este identificación PERM será continuada en Español.

Dear Medicaid and/or CHIP Provider:

The Centers for Medicare & Medicaid Services (CMS), in partnership with the states, is measuring improper payments in Medicaid/CHIP under the Payment Error Rate Measurement (PERM)[1] program.

Reason for Selection: A claim submitted by or on behalf of you/your organization has been randomly selected for review under this program. The review will be completed by CMS' review contractor, NCI Information Systems, Inc.

Action: Send Additional Documentation: A request for the medical/supporting record was sent to you on xx/xx/xxxx for the beneficiary listed on the enclosed Claim Summary. Thank you for your response to the request. It has been determined by the reviewer, however, that additional documentation is needed to complete the review of this claim. **Your cooperation in submitting the additional documentation to us within fourteen (14) days is essential to ensure that the claim is accurately reviewed to determine proper payment.** Federal regulations require that you provide the documentation to support claims for Medicaid/CHIP services upon request[2]. **Providing medical records for Medicaid/CHIP patients does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization *IS NOT REQUIRED* to provide medical records in response to this request.** CMS and its contractors will remain in compliance with the Privacy Act and regulations.

When: [||**MedrecDueDate**||]
Please provide the requested documentation by [||**MedrecDueDate**||]. **A response is still required by [||MedrecDueDate||] even if you are unable to locate the requested information.**

Consequences: If you fail to deliver the requested additional documentation or contact us by [||**MedrecDueDate**||], the claim will be cited as an erroneous payment and your state agency may pursue recovery of payment for this claim from you.

[1] 42 CFR §431.804; Social Security Act Section 2107(b)(1) [42 CFR §431.950 et seq]; 45 CFR parts 160 and 164
[2] 42 CFR §431.950

Assistance: The pages that follow provide identifying information for the claim selected for review, requested documentation, and submission instructions. Should you require additional information or have questions, please contact our Customer Service Representatives at (800) 393-3068, Medical Records Manager Allison Keeley at PERMRC_ProviderInquiries@nciinc.com, or your state PERM representative, _____, at _____ or _____.

Payment Error Rate Measurement (PERM)
Instructions for Submitting Requested Records/Documentation

To comply with this request, providers should review the attached Claim Summary page that identifies the specific patient, date of service, and the service(s) selected for review. Gather the documents shown on the attached Cover Sheet which are generally those needed to support the billed service(s). Please be sure that documentation (Notes, Plan of Care, etc.) issued from electronic records are signed and dated (electronic signature acceptable if permitted by state regulations). Once the documents are gathered, please choose **ONE** of the following methods to submit the records/documentation to the PERM Review Contractor.

1. Fax

a) Place PERM Cover Sheet on top of each record submission.
b) If your facility has ***more than one*** PERM ID request, please fax each submission separately.
c) Please submit documentation for each PERM ID in as few fax transmissions as possible.
d) Fax documents to**: 1-804-515-4220**

2. Mail

a) Place PERM Cover Sheet on top of each record submission.
b) All documents must be complete and legible.
c) Please do not staple or paper clip any pages together.
d) If you choose to send the documentation on USB Flash Drive, CD, or DVD, the file(s) must be ***encrypted.*** Please submit the password for the encrypted USB Flash Drive, CD, or DVD via email to PERMRC_Encryption@nciinc.com and include the PERM ID in the subject line. **Please note that USB flash drives cannot be returned to providers.**
e) Mail requested documentation to:

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3. Electronic Submission of Medical Documentation (esMD)

Providers with an established relationship with a Health Information Handler (HIH) are encouraged to have their HIH submit the requested medical documentation via the gateway to **Electronic Submission of Medical Documentation (esMD). <u>If your facility does not have an established relationship with an HIH, esMD will not be an available submission method.</u>** For more information, see http://www.cms.gov/esMD/. Please ensure that any documents submitted through esMD are routed to PERM NCI Inc.

If you choose to submit medical records via CMS's esMD system, you must enter the Reference ID (PERM ID #) from the records request letter into the ESMD CASEID field. If you enter any other information in this field, the system will not be able to identify the record automatically which will result in additional processing time.

<u>NOTE:</u> We are not authorized to reimburse providers/suppliers for the cost of copying or mailing records. Therefore, we cannot accept invoices for copying service fees.

Payment Error Rate Measurement (PERM)

REQUEST FOR RECORDS COVER SHEET

PERM-ID: [||PermID||]

Date: [||MRReSubDate||]

Beneficiary Name: [||BeneficiaryName||]
Date of Birth: [||BeneficiaryDOB||]
Beneficiary ID: [||BeneficiaryID||]
Date(s) of Service: [||DOSFrom||] - [||DOSTo||]
Category 1: Inpatient Hospital Services
Record Submission Due Date: [||MedrecDueDate||]

Billing Provider Number: [||ProviderID||]
Billing Provider Name: [||ProviderName||]

Please indicate # of pages in submission: _____ pages

Please help ensure accurate processing by placing this page on top of the records you are submitting.

The following **additional** documentation is needed:

Details regarding the specific documentation the PERM RC needs to complete the review will be listed in this space.

Payment Error Rate Measurement (PERM)
Claim Summary

Please refer to the Request for Records Cover Sheet for a list of documents to submit in support of the billed service(s) below.

Billing Provider Number: [||ProviderID||]
Beneficiary/Patient Name: [||BeneficiaryName||]
Beneficiary ID: [||BeneficiaryID||]
Date of Birth: [||BeneficiaryDOB||]
Date(s) of Service: [||DOSFrom||] - [||DOSTo||]

Request Date: [||MRReSubDate||]
PERM-ID: [||PermID||]
Claim Category: [||ClaimCatNum||]
State Claim ID: [||StateClaimID||]
DUE DATE: [||MedrecDueDate||]

Diagnosis Code	Procedure Code	NDC Code	Rx Number	DRG	Amount Paid
[||Diag1||]	[||Proc1||]	[||NdcCode1||]	[||RxNumber1||]	[||Drg||]	[||PaidAmt||]
[||Diag2||]	[||Proc2||]	[||NdcCode2||]			
[||Diag3||]	[||Proc3||]	[||NdcCode3||]			
[||Diag4||]	[||Proc4||]	[||NdcCode4||]			
[||Diag5||]	[||Proc5||]	[||NdcCode5||]			
[||Diag6||]	[||Proc6||]	[||NdcCode6||]			
[||Diag7||]	[||Proc7||]	[||NdcCode7||]			
[||Diag8||]	[||Proc8||]	[||NdcCode8||]			
[||Diag9||]	[||Proc9||]	[||NdcCode9||]			