# FY 2011 PERM Data Submission Instructions

**November 2010**

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# Section 1: Overview

The data requests for PERM are large and complex: the claims and payment data required for PERM include essentially all of a state's Medicaid and CHIP beneficiary-specific payments and many aggregate payments (together referred to as the PERM "universe"), as well as beneficiary and provider information for claims that are sampled for review.

These instructions are intended to guide state staff in the definition and application of data collection and quality control procedures for the PERM 2011 universe and details data. The instructions include information about PERM program areas, data sources, sampling units, required variables, state quality control checks, and data submission and security. Appendices include tables of required fields, a transmission cover sheet with quality control verification, and specific differences between the FY 2008 and FY 2011 PERM cycles.

Each member of the state's PERM team, including both technical and non-technical staff, should receive a copy of these instructions and review them early in the process.

## Initial Preparations for PERM

Developing PERM universes is a collaborative process between the states, CMS, and the Statistical Contractor (SC). The SC will provide assistance to each state in interpreting and applying the PERM data submission instructions. CMS will schedule meetings with state staff at the beginning of the PERM cycle to discuss the data request and to learn in detail about how the state adjudicates claims and processes other payments. The SC will continue to work with state staff to be certain that the state submitted all of the required PERM data in the PERM data submissions. States are encouraged to ask questions throughout the process to ensure mutual understanding of the data requirements and specifications.

To help ensure that all required data are included in the PERM submissions, each state should develop a PERM team that includes program, policy, technical and budget staff. From experience, CMS has identified that effective PERM teams include staff with expertise in areas such as:

- Program structure: single state agency and designated state agency functions, stand-alone/Medicaid expansion/combination CHIP program structure, managed care program structure and payment mechanisms, reimbursement policies involving at-risk, partial risk, or cost reconciliation arrangements, state-only funded programs adjudicated in MMIS
- Data sources: MMIS, health insurance premium payment (HIPP) payments, vendor data, other state agencies, county-paid services
- Technical aspects of claims adjudication: treatment of adjustments, denied/voided/rejected claims
- Field selection: reimbursement amounts for services matched with certified public expenditures, application of co-pays, original paid date
- Budget and finance: claims feeds for federal matching fund reports (e.g., quarterly CMS- 64 and CMS-21 reports)

## File Development and Submission Timeline

The PERM project cycle is expected to take approximately two years, with claims and payment record collection and sampling activities concentrated in the first four quarters (with states submitting data quarterly beginning January 18, 2011) and error rate calculation occurring at the end of the review cycle.

Exhibit 1 outlines the major activities in the data submission process, with data submission dates highlighted in yellow. To meet the PERM project deadlines, it is important to begin development of the PERM data submissions as early as possible in the cycle. States should expect to spend time in the first quarter of the fiscal year of the measurement (October through December) preparing for the first quarter data submission in January. States should expect to spend time in February and March responding to questions about the PERM universe, resolving any data issues found during data validation and quality control. Subsequent data submissions are due in April, July, and October.

**Exhibit 1: FY 2011 PERM Data Submission Timeline**

| Date | State Activities | SC/CMS Activities |
|---|---|---|
| **August 2010** | ✓ Determine if the state will submit via PERM Plus or routine PERM<br>✓ Select PERM team | ✓ Meet with select states to discuss the PERM Plus submission option<br>✓ Answer questions about PERM |
| **September 2010** | ✓ Schedule state orientation meeting | ✓ Organize state orientation meeting |
| **November - December 2010** | ✓ Participate in an orientation meeting<br>✓ Review Data Submission Instructions<br>✓ Ask questions and provide feedback | ✓ Participate in an orientation meeting<br>✓ Answer questions from and provide feedback to PERM states |
| **December 2010 - January 17 2011** | ✓ Code programs to provide PERM datasets<br>✓ Ask questions and provide feedback | ✓ Answer questions from and provide feedback to PERM states |
| **January 18, 2011** | ✓ Submit Q1 PERM universe data to the SC | ✓ Receive Q1 PERM universe data from states |
| **January 18 - February 2011** | ✓ Work with SC to resolve issues identified during the data validation and QC process | ✓ Begin SC data validation and QC process |
| **March 2011** | ✓ Work with SC to resolve issues identified QC of PERM universes | ✓ Perform QC review of PERM universes<br>✓ Select Q1 samples |
| **Within 2 weeks** | ✓ Submit Q1 PERM details data to the SC within 2 weeks of receipt of the sample | ✓ Receive Q1 PERM details data from states, format the data, and transmit the formatted details to the RC |
| **Within 30 days** | ✓ Work with SC to resolve issues | ✓ Format details data, and transmit the formatted details to the RC |
| **April 15, 2011** | ✓ Submit Q2 PERM universe data to the SC | ✓ Receive Q2 PERM universe data from states |

| Date | State Activities | SC/CMS Activities |
|---|---|---|
| **April 15 - June 2011** | ✓ Work with SC to resolve issues | ✓ Perform QC<br>✓ Select Q2 samples |
| **Within 2 weeks** | ✓ Submit Q2 PERM details data to the SC within 2 weeks of receipt of the sample | ✓ Receive Q2 PERM details data from states, format the data, and transmit the formatted details to the RC |
| **Within 30 days** | ✓ Work with SC to resolve issues | ✓ Format details data, and transmit the formatted details to the RC |
| **July 15, 2011** | ✓ Submit Q3 PERM universe data to the SC | ✓ Receive Q3 PERM universe data from states |
| **July 15 - September 2011** | ✓ Work with SC to resolve issues | ✓ Perform QC<br>✓ Select Q3 samples |
| **Within 2 weeks** | ✓ Submit Q3 PERM details data to the SC within 2 weeks of receipt of the sample | ✓ Receive Q3 PERM details data from states, format the data, and transmit the formatted details to the RC |
| **Within 30 days** | ✓ Work with SC to resolve issues | ✓ Format details data, and transmit the formatted details to the RC |
| **October 17, 2011** | ✓ Submit Q4 PERM universe data to the SC | ✓ Receive Q4 PERM universe data from states |
| **October 17 - December, 2011** | ✓ Work with SC to resolve issues | ✓ Perform QC<br>✓ Select Q4 samples |
| **Within 2 weeks** | ✓ Submit Q4 PERM details data to the SC within 2 weeks of receipt of the sample | ✓ Receive Q4 PERM details data from states |
| **Within 30 days** | ✓ Work with SC to resolve issues | ✓ Format details data, and transmit the formatted details to the RC |

## Section 2: Universe File Specifications

Each state in the PERM cycle must submit quarterly universe data to the SC. Universe data files are essentially very long "lists" of nearly all the Medicaid and CHIP beneficiary-specific payment records adjudicated by the state during the quarter, including both paid and denied claims. In the universe submission, each payment record only needs to contain a small number of data elements or fields; most of the fields associated with a claim are submitted only for the claims sampled for review in PERM (as described in Section 3).

The data for a PERM universe file may be compiled from the MMIS, a data warehouse, HIPP payment files, county and state agency systems, vendor payment systems, managed care files, and a variety of other sources. The state must divide the PERM universe data into four program areas: Medicaid fee-for-service, CHIP fee-for-service, Medicaid managed care, and CHIP managed care, and provide the data at the appropriate "payment level" to support consistent sampling and review across states.

The complete universe files are used to select the random sample of claims, line items, or payments for PERM review. To ensure that the sample drawn from the data is truly representative of the state's payments, each payment matched with federal Medicaid (Title XIX) or CHIP (Title XXI) funds should be included one time in the universe so that each payment has a chance, but only one chance, of being sampled for review.

### Universe Parameters

The PERM data submission is bound by the following three major parameters, each of which is described in more detail below:

- Date
- Program
- Payment type

This section defines and discusses these three parameters, with specific details around which payments are to be included in the PERM data submission, how adjusted claims, denied claims, and zero-paid claims should be handled, and which types of payments are specifically excluded from the PERM universe.

#### *Date*

PERM universes include claims and payments originally paid (or denied) during the federal fiscal year under review. For example, for the FY 2011 PERM cycle, the state's PERM universe includes claims and payments with original dates of payment between October 1, 2010 and September 30, 2011.

States submit PERM data quarterly, including all claims with an original date of payment within the federal fiscal quarter. Data is due to the SC fifteen days after the end of each quarter. See Exhibit 2 for the data submission due dates for FY 2011 and the paid claim dates to be included in each quarterly submission.

**Exhibit 2: Federal Fiscal Quarters and PERM Data Submission Dates, FY 2011**

| FY 2011 Quarter | Claim Date Paid | Data Submission Due |
|---|---|---|
| Quarter 1 | October 1 – December 31, 2010 | January 18, 2011 |
| Quarter 2 | January 1 – March 31, 2011 | April 15, 2011 |
| Quarter 3 | April 1 – June 30, 2011 | July 15, 2011 |
| Quarter 4 | July 1, 2011 – September 30, 2011 | October 17, 2011 |

To support consistency across states, PERM relies on the original paid date to determine whether a payment falls within a given cycle measurement. If a state originally paid a claim during the cycle under review, but adjusted the claim after the PERM measurement period, the claim should be included in the PERM data submission based on the original paid date. Conversely, if a claim's original paid date is prior to the PERM measurement period, but an adjustment falls within the PERM measurement period, the claim would **not** be included in the PERM data, again, based on the original paid date.

States often make managed care capitation payments prospectively (e.g., on the 25th of the month prior to the month of coverage) or retrospectively (e.g., in the month following the month of coverage). Include managed care capitation payments in the PERM data submission based on paid date as well.

- *Prospective example:* A state makes a capitation payment on December 25, 2010 for services in January 2011. The state includes the payment with the PERM quarter 1 data submission.
- *Retrospective example:* A state makes a capitation payment on October 5, 2010 for services in September 2010. The state should include the payment with the PERM quarter 1 data submission.

### *Program*

Generally, states include in the PERM data submissions all beneficiary-level claims and payments and certain aggregate payments for which the state receives federal financial participation (FFP) through Title XIX or Title XXI. (Limited exclusions are discussed in the next section.) States include claims and payments in PERM regardless if the state requested service or administrative match for the claims. Specific examples of claims and payments included in the PERM universe are:

- Regular fee-for-service (indemnity) claims
- Managed care premium payments
- Other payments made by the state on behalf of beneficiaries, including primary care case management (PCCM) payments, HIPP payments, capitated non-emergency transportation (NET) payments, and other capitated payments

- Payments made on the basis of an all-inclusive visit rate or "encounter rate." States often make these types of payments to federally qualified health centers (FQHCs) and certain other providers.
- Payments made to a provider in aggregate for which the underlying rate calculation methodology is based on individual beneficiaries

### *Identifying Medicaid and CHIP*

States include both Title XIX and Title XXI matched payments in the PERM data submissions. As CMS must report separate error rates for the Medicaid and CHIP programs, the state must separate PERM data submissions between Title XIX and Title XXI and submit these in separate PERM universe files each quarter. States should separate claims into the Medicaid or CHIP universe based on:

1) The federal money source, not the program design. Payments for Medicaid expansion-type CHIP programs or Medicaid expansion groups that are matched by Title XXI federal financial participation are included as CHIP claims or payments. States having both a Medicaid-expansion type CHIP program and a stand-alone CHIP program would include claims and payments from both Title XXI programs in the PERM CHIP universe file.
2) The beneficiary's eligibility status during the dates of service at the time the claim was paid (adjudicated), not the beneficiary's eligibility status at the time the state selects the data for PERM

Include in the PERM claims file all payments that are paid for in whole or in part by Title XIX federal financial participation (FFP) dollars, as well as those payments considered for Title XIX FFP dollars but denied.

Also include in the PERM claims file all Medicaid expansion and/or stand-alone CHIP payments in the PERM submission, including payments that are paid for in whole or in part by Title XXI FFP dollars, as well as payments submitted as Title XXI services but denied.

The Fields for Universe Submission table in Appendix A also includes a field called "Funding code." States may populate this field with any state-specific value that identifies, or helps identify, that the state requested federal Title XIX or Title XXI match for the claim or payment.

### *Service expenditures and administrative expenditures (both Title XIX and Title XXI)*

PERM universes include only payments representing services paid or denied (or for managed care, a capitation payment purchasing a package of services). PERM includes payments made for services received by individual beneficiaries that are matched either at the medical services match rate or that receive FFP as an allowable administrative cost.

PERM universes do not include payments solely made for administrative functions, such as payments to fiscal agents, salaries of state employees, or funding for program outreach. In instances where rates blend administrative and service payments, the entire payment is included in the PERM universe.

## Payment Type

### *Denied claims*

Denied claims are claims that are adjudicated in the state's payment system but denied for payment. States submit denied claims as part of the state's PERM universe. In some instances, states may not be able to determine if a denied claim should be assigned to the Title XIX or the Title XXI program (e.g., a claim that is denied due to an invalid beneficiary identifier). Please discuss treatment of these denied claims with the SC.

### *Zero-paid claims*

A zero-paid claim is a claim for which the state had no financial liability. For example, claims may be zero-paid due to, third party liability, a Medicare crossover payment exceeding the state allowable charge, or for spenddown beneficiaries who have not met their financial obligations. Include zero-paid claims in the PERM universe submissions.

### *Adjudicated claims*

States should only include fully adjudicated claims and payments in the PERM submissions. Claims that are submitted by providers that are "rejected" from the claims processing system prior to adjudication are not part of the PERM review. Often claim rejection occurs in a pre-processor or translator prior to the system assigning the claim an internal control number.

### *Beneficiary-level claims and payments*

PERM data submissions will largely be comprised of beneficiary-level claims and payments. These include fee-for-service, managed care, and fixed payments, as discussed below. States submit separate universes for fee-for-service (which includes fixed payments) and managed care payments, and the SC draws a separate sample from the fee-for-service and managed care universes. (Claims and payments excluded from PERM are addressed in the following section.)

***Fee-For-Service Payments***

Fee-for-service payments are all payments made on a fee-for-service/indemnity basis. These include:

- Traditional fee-for-service payments to physicians, hospitals, pharmacies, home health agencies, LTC facilities, etc.
- Medicare crossover claims
- Fee-for-service claims for services carved out of managed care
- Fee-for-service claims paid for retroactive eligibility periods

***Managed Care Payments***

Include in the managed care universe full and partially capitated payments, including:

- Premiums for "full risk" indemnity insurance such as payments to HMOs, MCOs, PIHPs, HIOs
- Payments to service-specific providers paid on a capitated/at-risk basis (e.g., pharmacy, mental health)
- Condition-specific managed care payments for special needs beneficiaries (e.g., at-risk payments for HIV/AIDS)
- Certain non-capitated, beneficiary-specific payments made to managed care organizations such as delivery supplemental payments or "kick" payments which are paid at a negotiated rate

While full-risk payments to managed care organizations are clearly part of the managed care universe, payments associated with certain types of capitated programs may be more appropriately included in the fee-for-service universe. The SC will work with each state to evaluate state programs and determine if program payments most conform to the PERM managed care definition or if the payments should be included in the fee-for-service universe instead.

***Fixed Payments***

Certain payments are included in the PERM fee-for-service universe for sampling but are not subject to medical review like other fee-for-service claims. These payments, referred to as "fixed payments" for PERM purposes, include a variety of payments made to providers or vendors such as:

- Monthly primary care case management fees paid to providers participating in a PCCM program
- HIPP payments made to purchase or subsidize employer-sponsored insurance
- Capitated non-emergency transportation vendor payments
- Fixed beneficiary-specific pharmacy dispensing fees (e.g., a state pays nursing home pharmacies a monthly fixed amount per beneficiary)

The SC will work with the state to evaluate state programs and services and determine if any meet the PERM fixed payment definition and should be included in the fee-for-service universe.

*Aggregate Payments*

While most Medicaid and CHIP payments for services are paid at the beneficiary level, states also calculate and pay for some services on behalf of a group of beneficiaries. PERM broadly refers to these as "aggregate payments." Unless otherwise specified by CMS, aggregate payments for services to beneficiaries are included in the PERM universe. Aggregate payments are included in the PERM universe regardless of whether the state claims FFP at the medical services match rate or as an allowable administrative cost.

Examples of aggregate payments are pay-for-performance incentive payments made to individual providers based on the claims experience of a group of beneficiaries; reimbursement to counties for non-emergency transportation services provided to all Medicaid beneficiaries

residing in that county; and fees paid to a case management vendor based on the number of beneficiaries enrolled in the Medicaid program each month. In some cases, states may determine payment at the individual level but maintain payment records at the aggregate level.

CMS and the SC will work with the state to determine how aggregate payments should be submitted and reviewed for PERM.

### *Claims and Payments to Exclude from PERM*

Some claims and payments for which states receive FFP through Title XIX or Title XXI are explicitly excluded from PERM either by regulation or in accordance with established policy. States should not include the following claims or payments in the PERM submission when the payment is not beneficiary-specific:

- Disproportionate share hospital (DSH) payments
- Drug rebates
- Grants to state agencies or local health departments
- Cost-based reconciliations to not-for-profit providers or federally qualified health centers
- Gross payments
- Mass adjustments

In addition, states should not include Medicare premium payments ("buy-in") in the PERM data submission. The SC will collect these payments from CMS to include in each state's universe prior to sampling.

#### *Encounter data*

States should not include encounter data or "shadow claims" in the PERM submissions. For PERM purposes, encounter data is defined as informational-only records submitted to a state by a provider or a managed care organization (MCO) for services covered under a managed care capitation payment. States often collect this data in order to track utilization, assess access to care, and possibly compute risk adjustment factors for at-risk managed care contractors. However, these are not claims submitted for payment. While encounter data are beneficiary-specific, encounters do not represent an actual payment made by the state.

#### *Payments for administrative functions*

As noted above, PERM claims and payments represent services to beneficiaries. Payments made entirely for administrative functions are not included in the PERM review and states should not include these in the PERM submissions. These include payments such as state staff salaries, fiscal agents and other administrative vendors, and outreach funding. In cases in which a state blends dollars for beneficiary services with administrative payments into a single reimbursement rate, the state should submit the entire payment for PERM review.

### *Adjusted Claims*

States are required to remove claim or payment adjustments from the PERM data submissions. Only the original paid amount should be submitted in the PERM universe.

## Data Sources

States generally draw a majority of PERM data from their MMIS. However, states often maintain other payment systems that record payments matched with Title XIX or Title XXI funds (and for which the state does not also maintain a payment recorded in MMIS). States must include all payments, including those from non-MMIS systems, in the PERM data submissions. PERM affords states flexibility to submit data from systems outside MMIS as separate files from the MMIS data.

When reviewing possible data sources, states are advised to consider sources such as:

- Claims paid by separate vendors or third party administrators
    - Pharmacy
    - Dental
    - Vision
- Claims paid by state agencies (not the Medicaid agency)
- Mentally Retarded/Developmentally Disabled (MR/DD) services
- State-owned facilities such as nursing homes
- Waiver services (including consumer-directed individualized budgets)
- Claims paid by counties
- Transportation provider payment systems
- Case management costs
- Stand-alone or "manual" systems
- HIPP payments
- Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Indian Health Service (IHS) clinics and facilities
- Systems that produce payments such as PCCM payments and non-emergency medical transportation broker capitation payments

To determine if a state is capturing payments from all of the data sources, state staff should "follow the money" by reviewing the state's federal financial reports. If a state determines that data from multiple sources populates the CMS-64 and/or CMS-21 Financial Reports, the state should evaluate these data sources to identify claims and payments to include in the PERM data submission.

Note that not all claims processed in MMIS are matched with Title XIX or Title XXI funds. Do not include in the PERM submissions state-only funded services or services provided with financial funds from any federal programs other than Title XIX or Title XXI.

## Sampling Units in the PERM Submission

PERM universe data will have one record for each "sampling unit." States must provide universe data at the sampling unit level. A sampling unit is a line item, fixed payment, or other individually-priced service tied to a single beneficiary. If a payment amount is determined at the detail item or "line" level, the line item is the sampling unit. If the payment amount is set at the claim level, the sampling unit is at the claim or "header" level.

A header level sampling unit has a paid amount that is not associated with any specific line or service; rather, it is based on days, groups of services and/or other related information, encounter rates, or point of sale transactions. A line level sampling unit has a paid amount on the record for a specific service.

Please note, if payment amount determination is made for the entire claim, regardless of the number of lines or where the payment is carried in the system, it is a header level payment. If each line in a claim stands the chance of being paid or denied individually, these are line level payments.

When developing data specifications for PERM, it is important to carefully review the many types of claims paid by the state so that the appropriate header or line level payment is selected. Some states have found it helpful to review each state claim type or other payment indicator to identify claims as header or line level payments (but also be aware of exceptions to the claim type payment "rules").

### *Header Level Example*

For those states using a prospective payment or diagnosis-related groups (DRG) systems for inpatient stays, the smallest independently priced item is the DRG itself. In this case, the DRG (or claim header) is the sampling unit. When the DRG is the sampling unit, the universe file would include a single record for each inpatient hospital claim, with the amount paid field equal to the amount paid for the entire claim. If the state determines that the sampling unit is the header, the state should not include in the PERM universe the records for the detail lines associated with the header (often these are zero-paid lines). Similarly, if the inpatient stay is priced as an all-inclusive per diem payment amount, the sampling unit would be at the claim header level. Exhibit 3 provides an example of a header level sampling unit.

**Exhibit 3: Example of a Header Level Sampling Unit**

| *Payment Level* | *Claim Type* | *ICN* | *Line Number* | *Date Paid* | *Amount Paid* | *Service Code* |
|---|---|---|---|---|---|---|
| H | Inpatient | 12345678 | 0 | 10/1/2010 | $1000.00 | DRG |

### *Line Level Example*

Most physician claims are paid by individually-priced procedure codes recorded at the line or detail level. In these cases, the state would submit the physician claims in the universe file at the line level. Each record or sampling unit will represent a claim line/detail and the amount paid for that line/detail. For a lab claim with several separately priced tests, each line item on the claim would be defined as a sampling unit and sampled separately. A claim for lab tests paid on a bundled basis would be treated as a single line level sampling unit. For claims submitted at the line level, the state should not also include a header level record (this would essentially "double" the paid amount associated with the claim in the PERM universe). Exhibit 4 provides an example of line level sampling units.

Multiple units of service recorded on a single line should not be divided into multiple sampling units if the units were priced and paid on the same line. For example, a procedure code having 2 units should *not* be made into 2 records of one unit each.

**Exhibit 4: Examples of Line Level Sampling Units**

| *Payment Level* | *Claim Type* | *ICN* | *Line Number* | *Date Paid* | *Amount Paid* | *Service Code* |
|---|---|---|---|---|---|---|
| L | Physician | 12345678 | 1 | 10/1/2010 | $10.00 | HCPCS |
| L | Physician | 12345678 | 2 | 10/1/2010 | $15.00 | HCPCS |
| L | Physician | 12345678 | 3 | 10/1/2010 | $20.00 | HCPCS |

### *Payment Level Identification Challenges*

For certain types of claims and payments, it can be difficult to accurately identify the appropriate "payment level" for PERM purposes. States should pay particular attention to FQHC payments and other clinic payments, Medicare crossover claims, payments made to state-owned facilities or out-of-state facilities, and compounded drugs, which may be atypical from other payments for similar services. In some states, FQHCs also submit unpaid, informational line details with procedure codes. These informational line items should not be included in the PERM universe. Medicare crossover claims are often paid on the basis of the type of service, and the universe file will need to capture these payments at the header or line item level, as appropriate to each payment. Some states pay state-owned facilities differently than private providers. If this is the case, be certain to select the appropriate header or line value for the PERM universe.

A sampling unit should never be represented multiple times within a universe file, or included in more than one universe file across programs or across quarters. (The same ICN and line number combination should not repeat.) If a claim is included at the header level, the associated lines should not be included in the universe. Likewise, if a claim is included at the line level, the associated header should not be included in the universe.

Again, the SC will work with the state to evaluate payments and help determine if the state should include the payment in the PERM universe at the line level or the header level.

## Fields in the PERM Universe Submission

As noted above, while the universe must contain a record for every payment that meets the PERM universe criteria, each payment record in the fee-for-service universe only needs to contain a relatively small number of data elements or fields. After the SC samples fee-for-service claims for review, the state will then submit a larger number of fields, including beneficiary and provider information, only for the sampled claims. The sampled claim details submission is described in Section 3.

For the managed care universe, we require states to submit all of the fields needed for review as part of the universe submission. Therefore, the managed care universe submission contains more required fields than the fee-for-service universe. However, because the managed care universe already contains the fields needed to review sampled managed care claims, states generally do not need to submit a second detail submission for sampled managed care claims.

Appendix A contains a list of the fields required for each payment record in the fee-for-service and managed care universe submissions. Some of these fields, such as ICN, line number, and source location allow the state, SC, and RC to identify the sampled payment in the state's system. Many fields, such as date paid, amount paid, claim type, provider type, managed care program indicator, and payment status are used by the SC to validate that the universe is complete and accurate. Some of the required fields, such as funding code and fixed payment indicator, are used to ensure that payments are assigned to the appropriate PERM universe prior to sampling. Many of the managed care-specific fields such as beneficiary ID, rate indicator, aid category, and coverage location are used by the RC to conduct the managed care payment review. States may also submit state-defined fields with the data if desired.

Appendix B contains a table of fields required for the sampled claim details submission. Many of these required fields assist the RC in requesting records, and the provider in identifying and submitting the medical record associated with the sampled claim.

Please carefully review the tables and Appendix A and Appendix B, including the "Notes/Suggestions" column. This column provides information essential to understanding the PERM field requirements.

## Section 3: Sampled Claim Details File Specifications

The Medicaid and CHIP fee-for-service universes include an extract of the claims information for all adjudicated sampling units (paid claims and denials) for each quarter. From the universe claims extract, the SC will select a random sample of payments. The SC will return the sampled claims to the state. For the sampled fee-for-service claims, the state will then provide to the SC a file with details for the sampled payments. This sampled claim details submission will contain information needed to assist the RC in requesting records, and the provider in identifying and submitting the medical record associated with each sampled claim.

### Sampled Claim Details Data

States will return to the SC detailed information on each sampled claim. The detailed information should include complete header and line information for the sample. For example, if a claim pays on a line basis and the SC sampled line 2, the information returned by the state should include information from the header and all lines associated with that claim header, including line 2 and all other lines. Likewise, if the SC sampled a payment provided in the universe as a header level claim, the state should return in the details submission all lines associated with that claim, as well as the sampled claim header.

As noted above, the sampled claim details submission intends to include all fields necessary for the RC to request a medical record from the provider and for the provider to identify and submit the associated record. Identifiers for both the billing provider and the performing provider should be included for all fee-for-service claims in the sample, along with the providers' addresses and telephone numbers. Note that if a required medical record cannot be obtained from the provider, the payment will be considered fully in error. Therefore, states are advised to provide complete and up-to-date provider contact information. In some cases, such as when the billing provider in MMIS is a state agency or other organization, the state may need to locate additional information on the performing provider and submit the additional information for the associated sampled claim. Therefore, we strongly recommend reviewing sampled claim detail information to validate that the provider information submitted with each sample is the correct provider for the RC to contact to obtain the record that supports the claim.

Unlike previous cycles, states will not be required to submit adjustments with their sampled claim details. The RC will collect any adjustments made within 60 days to sampled claims during the review process. This applies to both fee-for-service and managed care samples. While state policies generally allow adjustments to be made more than 60 days after the original paid date, only the adjustments made within 60 days will be considered for PERM review purposes, per federal regulation. The RC will work with each state to identify mechanisms and data fields to appropriately account for adjustments during the review.

### Fields in the PERM Details Submission

Appendix B contains a list of the fields required in the sampled claim details submission. The SC will work with the state to determine if certain fields are or are not applicable to certain claim or payment types.

## Section 4: Quality Review

States are responsible for performing a quality review of their PERM data submissions each quarter before submitting files to the SC. Quality review saves time and resources for both the state and CMS contractors by identifying data problems early in the PERM process. Exhibits 5 and 6 contain suggested minimal quality control checks for states to complete.

**Exhibit 5: Minimum Universe Submission Quality Control Checks**

| Quality Review | Suggested Tests |
|---|---|
| 1) Ensure all required fields are reported in the universe file | ○ Prepare a list of all fields in the universe file and compare it to the list of fields in Appendix A<br>○ Identify any missing fields<br>○ Determine why the field is missing; if the state does not report a field, let the SC know when submitting the file |
| 2) Check that key fields are properly formatted | ○ Check that key fields are not truncated or contain extra data. Review fields such as:<br>- ICN/TCN<br>- Line number<br>- Paid Amount |
| 3) Check that the paid date for all records is for the appropriate quarter for FY 2011 | ○ Review the values in the paid date field |
| 4) Confirm Medicaid (Title XIX) and CHIP (Title XXI) claims are appropriately allocated to the correct universe | ○ Review programming logic and outputs to make certain that claims in the Medicaid universe were matched with Title XIX funds and claims in the CHIP universe were matched with Title XXI funds |
| 5) Confirm that fee-for-service and managed care claims are appropriately allocated to the correct universe | ○ Review programming logic and outputs to make certain that claims are allocated to the correct universe.<br>○ Review notes from intake discussion and subsequent communications with the SC and CMS to ensure the universes contain the required types of claims and payments |
| 6) Each payment is represented only one time in the universe | ○ Confirm that there are no ICN-line number combinations repeated in the universe |
| 7) Conduct a comparison of the CMS-64/21 reports to the PERM universe submissions | ○ Compare PERM universe totals to either two previous quarters' CMS-64/21 reports, or to the current quarter's CMS-64/21 reports<br>○ Look for major dips or spikes or "significant" differences<br>○ Submit comparison results to the SC for each quarterly PERM universe submission |

**Exhibit 6: Minimum Sampled Claim Details Submission Quality Control Checks**

| Quality Review | Suggested Tests |
|---|---|
| 1) Ensure all required fields are reported in the detail file | ○ Prepare a list of all fields in the data submission and compare it to the list of fields in Appendix B<br>○ Identify any missing fields<br>○ Determine why the field is missing; if the state does not report a field, let the SC know when submitting the file<br>○ Sort claims by logical groupings (e.g., claim types, provider types) and compare submitted claims |
| 2) Check that key fields are properly formatted | ○ Check that key fields are not truncated or contain extra data. Review fields such as:<br>- ICN/TCN<br>- Line number<br>- Billing provider number<br>- Beneficiary ID<br>○ Paid Amount |
| 3) Check that the paid date for all records is for the appropriate quarter for FY 2011 | ○ Review the values in the paid date field |
| 4) Claim headers and all details (including the sampled line item and all other line items associated with the same claim or all line items associated with the sampled claim) are included for each sampling unit | ○ Review details for each payment level, making sure that if the sample is a line level claim, the details contain all lines associated with that claim<br>○ Repeat process for header level records |
| 5) Review provider information | ○ Verify that provider information, including addresses, phone numbers, and fax numbers, is complete and up-to-date |

## State PERM Universe Data Quality Guidance

States are required to compare their Medicaid and CHIP PERM universes to CMS-64 and CMS-21 Financial Reports, respectively, to ensure that the universes are complete and accurate. Comparing the universe data to the CMS Financial Reports ensures that no programs (likely not in MMIS) that appear on the CMS Financial Reports have been omitted from universe data and that the state is capturing all necessary data sources in the PERM universe.

### *CMS-64 and CMS-21 Forms to Use*

CMS-64 and CMS-21 Forms should be finalized 30 days after the end of the quarter. PERM universe data submissions are due 15 days after the end of the quarter. States will, therefore, have two options:

1. Compare a quarter's universe submission to the two previous quarters' CMS-64 and CMS-21 Financial Reports. The table below describes the timeframe for which these reports are completed. For example: FY 2011 Q1 Universe Data Submission (Oct.-Dec., 2010) would be compared to Q3 (Apr.-June, 2010) and Q4 (July-Sept., 2010) Financial Reports.

| Universe Data Submission Timeframe | CMS-64/21 Financial Reports for Comparison |
|---|---|
| FY11 Q1 | FY10 Q3 & FY10 Q4 |
| FY11 Q2 | FY10 Q4 & FY11 Q1 |
| FY11 Q3 | FY11 Q1 & FY11 Q2 |
| FY11 Q4 | FY11 Q2 & FY11 Q3 |

2. Compare a quarter's universe submission to the current quarter's CMS-64 and CMS-21 Financial Reports when they are finalized.

### *Comparison*

States shall identify the portions of the CMS-64 and CMS-21 Financial Reports that are not appropriate to compare to PERM universes (excluded claims, drug rebates, adjustments, etc.), remove these from the CMS-64 and CMS-21 Financial Report Totals, and separate the CMS-64 and CMS-21 totals between Fee-For-Service (FFS) and managed care. States shall then compare the CMS-64 and CMS-21 Financial Report totals to their FFS and managed care PERM universes. The analysis is a ballpark comparison. States should look for major dips or spikes or "significant" differences between PERM universes and Financial Reports as defined by the state.

### *Submission Requirements*

States shall submit their comparison results to the Statistical Contractor for each quarterly PERM universe submission. In the results submitted, the state should confirm that no programs that appear on the CMS Financial Reports have been omitted from the universe and include an explanation for any significant variance the state may have found. If a payment is on the CMS Financial Report and qualifies for the PERM universe, it must be reflected in the universe data. A template the state can use to submit comparison results is provided in Appendix D. In addition, states may choose to submit supporting worksheets to the Statistical Contractor.

## Section 5: Data Transmission and Security

This section discusses the PERM data submission media, PERM data submission formats, transmission cover sheet and quality control verification, and data transmission and security.

### Submission Media

The SC's data systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, portable hard drives). It is preferred that states send their data via secure FTP (SFTP). However, if this is not an option, state may submit data on a CD or DVD. Do not send PERM data via email.

See the Data Transmission section below for information on passwords and encryption.

### Submission Formats

The SC prefers receiving data in one of three formats: SAS dataset, delimited file, or flat file.

- SAS dataset: PC-based SAS dataset
- Delimited file: comma delimited (.csv) or tab delimited text (.txt)
- Flat file: a universal text format with a single fixed record length and layout (also called a "flat format" or "ASCII format"). If the state submits text files, except for the first row of the field names, do not include any log or summary information at the beginning or at the bottom of the data file.

### Transmission Cover Sheet

The state must submit a transmission cover sheet with every data submission. Examples of the Medicaid fee-for-service and Medicaid managed care data transmission cover sheet and quality control verification are provided in Appendix C. The state may burn the transmission cover sheet on the CD or DVD with the data, email the cover sheet to the SC, or submit as a separate file through SFTP.

### Privacy

The SC is committed to protecting the confidentiality, integrity and accessibility of sensitive data. PERM states should comply with HIPAA Privacy and Security Rules, CMS Business Partners Systems Security Manual rules for sensitive data transfer, and state privacy and security rules. Any data that includes protected health information (PHI) and/or personally identifiable information (PII), such as beneficiary ID numbers, is considered sensitive data.

### Data Transmission

All data transmissions containing PHI or PII must conform to the FIPS 140-2 standards and comply with proper password protection and encryption procedures.

The SC will only accept data files via SFTP transmission or sent on hard media (e.g. CD, DVD) through the mail. Do not send PERM data via email.

The preferred method of data transmission is via SFTP.

**Follow these steps if sending data via SFTP:**

- Contact the SC to discuss the SFTP site, establish a SFTP connection, and test the SFTP prior to data submission
- Encrypt and password-protect data files
- Zip all PERM data files, including the Transmission Cover Sheet and file layouts, into a single zip file
- SFTP the zipped file
- Email a copy of the Transmission Cover Sheet and password(s) to the SC to indicate that the PERM data is available on the SFTP site

**Follow these steps if mailing data:**

- Zip files, as needed, based on file size
- Encrypt and password-protect data files, copy to a CD or DVD
- Label the CD or DVD "CMS Sensitive Information"
- Label the envelope "To be opened by addressee only"
- Address the envelope to the SC
- Mail the CD or DVD via a private delivery service (such as FedEx or UPS) or the USPS
- E-mail the Transmission Cover Sheet and password(s) for the data to the SC

## Appendix A
## Fields for Universe Submissions

When submitting the universe data to the SC, states are required to provide all of the fields listed in the tables below. The first table contains the fee-for-service fields. The second lists the managed care fields. Note that in the fee-for-service universe file, all fields are mandatory. This means every data element for every line item should be populated with a valid value.

### Universe – Medicaid Fee-For-Service and CHIP Fee-For-Service

| Standard Field Name | Standard Field Description | Notes/Suggestions |
|---|---|---|
| ICN | Unique claim identifier (e.g., ICN, TCN, other state issued number) | Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For "dummy" claims, be sure the ICN information can tie back to the payment.<br><br>If the ICN/Line Number alone is *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used. |
| Line number | Line item number | Indicate in documentation the line item number for headers (e.g., header line = 0) |
| Date paid | Original date of payment | |
| Amount paid | Total computable amount paid on the line or header | Total Computable Amount = Federal Share + State Share<br><br>Amount paid should be net of any co-payments, third-party, or other beneficiary liability |
| Claim type | Distinguish, for example, between inpatient, outpatient, professional, prescription, Medicare crossover, etc. | State data dictionary required |
| Funding code | Indicates the funding source for the claim or claim lines | State data dictionary required |

## Appendix A
## Fields for Universe Submissions

| Universe – Medicaid Fee-For-Service and CHIP Fee-For-Service | | |
|---|---|---|
| **Standard Field Name** | **Standard Field Description** | **Notes/Suggestions** |
| Payment status | Indicator if the claim is paid or denied | |
| Fixed payment indicator | Indicates where a payment is fixed | Suggest using 1= Fixed Payment, 0= Not a Fixed Payment |
| Payment level | Header level, line level | H = Sampling unit paid at the Header level<br><br>L = Sampling unit paid at the Line level |
| Provider ID | Provider identification number associated with the claim or claim line | |
| Provider type | Provider type or MSIS category or other similar variable | State data dictionary required |
| Provider specialty | Provider specialty for the claim or claim line | State data dictionary required |
| Service code | Procedure code, revenue code, or other payment code (often for, but not exclusive to, line level sampling units) | |
| Source location | The system of origin/location in which the sampling unit was adjudicated | If system operated outside the MMIS, the state should provide a crosswalk from the system to the location, e. g,, 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State |
| User option fields 1-5 | State supplied additional fields | |

## Appendix A
## Fields for Universe Submissions

| Universe – Medicaid Managed Care and CHIP Managed Care | | |
|---|---|---|
| **Standard Field Name** | **Standard Field Description** | **Notes/Suggestions** |
| ICN | Unique claim identifier (e.g., ICN, TCN, other state issued number) | Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For "dummy" claims, be sure the ICN information can tie back to the payment.<br><br>If the ICN/Line Number alone is *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used. |
| Date paid | Original date of payment | |
| Amount paid | Total computable amount paid of the payment | Total Computable Amount = Federal Share + State Share<br><br>Amount paid should be net of any co-payments, third-party, or other beneficiary liability |
| Managed care program indicator | Indicator of the program (TANF, PACE, LTC, Behavioral health) | State data dictionary required |
| Payment type | E.g., monthly capitation, delivery kick payment or other beneficiary-specific supplemental payment, individual reinsurance payment | State data dictionary required |
| Funding code | Indicates the funding source for the claim or claim lines | State data dictionary required |
| Provider ID | Medicaid/CHIP ID for the managed care organization | |

## Appendix A
## Fields for Universe Submissions

| Universe – Medicaid Managed Care and CHIP Managed Care | | |
|---|---|---|
| **Standard Field Name** | **Standard Field Description** | **Notes/Suggestions** |
| Beneficiary ID | Beneficiary Medicaid/CHIP number | |
| Beneficiary name | | State may submit according to state preference (e.g., can submit multiple variables for first, middle, and last name or a single variable containing beneficiaries full names) |
| Beneficiary rate indicator | "Procedure code" or other rate cohort indicator | State data dictionary required |
| Beneficiary aid category | Eligibility type | State data dictionary required |
| Beneficiary DOB | Beneficiary date of birth | |
| Beneficiary gender | | State data dictionary required |
| Beneficiary county | | State data dictionary required |
| Service area indicator | Indicator for the geographic service area if the service area is not the county | State data dictionary required |
| Source location | The system of origin/location in which the sampling unit was adjudicated | If system operated outside the MMIS, the state should provide a crosswalk from the system to the location, e. g,, 'HEALTHY KIDS' = City, State, 'CHIP MMIS' = Different City, State |
| Coverage period | Period of coverage this payment represents | May be prospective, concurrent, or retrospective |
| Payment status | Indicator if the claim is paid or denied | |
| User option fields 1-5 | State supplied additional fields | |

# Appendix B
# Fields for Details Submissions

| Details – Medicaid Fee-For-Service and CHIP Fee-For-Service | | |
|---|---|---|
| **Standard Field Name** | **Standard Field Description** | **Notes/Suggestions** |
| PERM ID | Unique indicator for each sampled unit as assigned by SC in the sampled claim file | Populated field will be provided to the state by the SC in the sampled claim file |
| ICN | Unique claim identifier (e.g., ICN, TCN, other state issued number) | Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For "dummy" claims, be sure the ICN information can tie back to the payment.<br><br>If the ICN/Line Number alone is *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used. |
| Line number | Line item number | Indicate in documentation the line item number for headers (e.g., header line = 0) |
| PERM state | State abbreviation | Populated field will be provided to the state by the SC in the sampled claim file |
| Sample year | Federal fiscal year under PERM review | Populated field will be provided to the state by the SC in the sampled claim file |
| Sample quarter | Quarter of the federal fiscal year under PERM review | Populated field will be provided to the state by the SC in the sampled claim file |
| Claim type | State claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim | |
| Payment status | Paid or Denied indicator for each claim or claim line. State should provide decodes | State data dictionary required |
| Medicare crossover indicator | Indicates that the claim is a crossover claim from Medicare to Medicaid | |

## Appendix B
## Fields for Details Submissions

| Details – Medicaid Fee-For-Service and CHIP Fee-For-Service | | |
|---|---|---|
| **Standard Field Name** | **Standard Field Description** | **Notes/Suggestions** |
| Amount paid header | Total computable amount paid at the claim header | Total Computable Amount = Federal Share + State Share<br><br>Amount paid should be net of any co-payments, third-party, or other beneficiary liability |
| Date paid | Date claim was adjudicated or paid; not the check date unless there is no adjudication date. This date should match the paid date submitted in the universe for the sampled claim. | |
| DOS from Clm | From date of service on the claim | |
| DOS To Clm | To date of service on the claim | |
| Beneficiary ID | Beneficiary ID number | |
| Beneficiary name | | State may submit according to state preference (e.g., can submit multiple variables for first, middle, and last name or a single variable containing beneficiary full name) |
| Beneficiary DOB | Beneficiary date of birth | |
| Beneficiary gender | Beneficiary gender code | |
| Beneficiary county | Beneficiary county | |
| Billing prov number | Billing provider ID number | |
| Billing prov name | Billing provider name | |
| Billing prov type | Billng provider type | |

## Appendix B
## Fields for Details Submissions

| Details – Medicaid Fee-For-Service and CHIP Fee-For-Service | | |
|---|---|---|
| **Standard Field Name** | **Standard Field Description** | **Notes/Suggestions** |
| Billing prov spec | Billing provider specialty code | |
| Billing prov addr 1 | Billing provider address first line. Note that the state may populate this data element with a contact name. | |
| Billing prov addr 2 | Billing provider address second line | |
| Billing prov city | Billing provider city | |
| Billing prov state | Billing provider state | |
| Billing prov zip | Billing provider zip code | |
| Billing prov phone | Billing provider phone number(s). Phone extensions are acceptable, as are multiple phone numbers up to 50 bytes. (e.g. '1234567890 OR 0987654321') | |
| Billing prov fax | Billing provider fax number | |
| Billing prov NPI | Billing provider's NPI, when available | |
| ICD9 proc code 1 | ICD-9/10 surgical procedure code 1 | |
| ICD9 proc code 2 | ICD-9/10 surgical procedure code 2 | |
| ICD9 proc code 3 | ICD-9/10 surgical procedure code 3 | |
| Diag 1 | Diagnosis code 1 (primary) | |
| Diag 2 | Diagnosis code 2 | |
| Diag 3 | Diagnosis code 3 | |

| Details – Medicaid Fee-For-Service and CHIP Fee-For-Service | | |
|---|---|---|
| **Standard Field Name** | **Standard Field Description** | **Notes/Suggestions** |
| Diag 4 | Diagnosis code 4 | |
| Diag 5 | Diagnosis code 5 | |
| DRG | Diagnosis Related Group (DRG) code, if applicable | |
| Source location | The entity identifier and location of the source that processed the claim. Is required for states that have multiple locations that process claims for the same universe file. | |
| Line item number | Line number of the individual line item | |
| Sampled ind | Indicates if the individual line was sampled | Yes = Y and No = N. If two lines in a single claim were sampled, each line is marked with a Y in the claim. For header level sampling units, all lines are marked with a Y. |
| Proc code line | Procedure code on the line (HCPCS code or CPT) as it was adjudicated | |
| Units paid | Number of units (services) paid or drug quantity dispensed | |
| Amount paid line | Total computable amount paid at the claim line | Total Computable Amount = Federal Share + State Share<br><br>Amount paid should be net of any co-payments, third-party, or other beneficiary liability |
| Proc mod 1 | Procedure Code Modifier - 1 on the line as it was adjudicated | |
| Proc mod 2 | Procedure Code Modifier - 2 on the line as it was adjudicated | |

| Details – Medicaid Fee-For-Service and CHIP Fee-For-Service | | |
|---|---|---|
| **Standard Field Name** | **Standard Field Description** | **Notes/Suggestions** |
| Rev code | Revenue code for the claim line. Note that ALL revenue codes should be submitted for a claim. A separate record should be created for each revenue code. | |
| Perf prov number | Performing (servicing) provider ID number | |
| Perf prov name | Performing (servicing) provider name | |
| Performing prov type | Performing (servicing) provider type | |
| Peforming prov spec | Performing (servicing) provider specialty code | |
| Perf prov addr 1 | Performing (servicing) provider address first line. Note that the state may populate this data element with a contact name. | |
| Perf prov addr 2 | Performing (servicing) provider address second line | |
| Perf prov city | Performing (servicing) provider city | |
| Perf prov state | Performing (servicing) provider state | |
| Perf prov zip | Performing (servicing) provider zip code | |
| Perf prov phone | Performing (servicing) provider phone number | Phone extensions are acceptable, as are multiple phone numbers up to 50 bytes (e.g. '1234567890 OR 0987654321') |
| Perf prov fax | Performing (servicing) provider fax number | |
| Perf prov NPI | Performing provider's NPI, when available | |

## Appendix B
## Fields for Details Submissions

| Details – Medicaid Fee-For-Service and CHIP Fee-For-Service | | |
|---|---|---|
| **Standard Field Name** | **Standard Field Description** | **Notes/Suggestions** |
| DOS from line | From date of service on the line | |
| DOS to line | To date of service on the line | |
| POS | Place of service | |
| TOS | Type of service | |
| NDC code | National Drug Code (NDC) | Made up of labeler(mfr) + product + pkg size = 4/4/2 or 5/3/2 or 5/4/1 configurations |
| Drug order date | Date drug was prescribed for a pharmacy claim | |
| Prescription number | Prescription number for the pharmacy claim line | |
| Prior authorization | Prior authorization number on the header or line | Prior authorization number will be the same on all lines if PA only available at the claim level |
| Date paid line | For those Medicaid systems that have paid dates at the line level (because they adjudicate each line separately), the date paid for that line, if different from the date of payment for the entire claim. | |
| Claim category fields | Fields from the state, such as category of service or MSIS code, that can be used to categorize the claim. | |
| User fields 1-5 | User-specific field that may contain unique state data that is important for the program but is not in the standard format. State may choose to leave this data element out, if desired. | |

**Appendix C**
**Transmission Cover Sheet and Quality Control Verification**

## Medicaid Fee-For-Service, Quarter 1

Complete and submit this cover sheet with every PERM data submission.

| | | | | |
|---|---|---|---|---|
| **State:** | | | | |
| **Date:** | | | | |
| **Quarter:** | | | | |
| **Contact person for data questions** | | | | |
| **Name:** | | | | |
| **Phone:** | | | | |
| **Email:** | | | | |
| **Title:** | | | | |
| **Organization:** | | | | |
| **Data Descriptions** *Complete information below. Please include a row describing the data documentation. Add more rows as necessary.* | | | | |
| **Data Description** (e.g., Q1 Medicaid FFS; data documentation) | **Data Filename** | **File Format** (e.g., text, Excel, SAS) | **File Media** (e.g., CD, DVD, FTP) | **Password Protected? (Y/N)** (if yes, send password separately) |
| | | | | |
| (Add rows if necessary) | | | | |

## Appendix C
## Transmission Cover Sheet and Quality Control Verification

| **Control Totals** *Add more tables as necessary*.**NOTE:** List the lines cont and total $$ by CLAIM TYPE, not universe totals. Add more rows as necessary to reflect each claim type. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Data filename:** | 0 | | | | | | | |
| **Month** | | | **Month** | | | **Month** | | |
| October | | | November | | | December | | |
| **Claim Type** | **Total Lines** | **Total $$** | **Claim Type** | **Total Lines** | **Total $$** | **Claim Type** | **Total Lines** | **Total $$** |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| (Add rows if necessary) | | | | | | | | |
| **Data filename:** | 0 | | | | | | | |
| **Month** | | | **Month** | | | **Month** | | |
| October | | | November | | | December | | |
| **Claim Type** | **Total Lines** | **Total $$** | **Claim Type** | **Total Lines** | **Total $$** | **Claim Type** | **Total Lines** | **Total $$** |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| (Add rows if necessary) | | | | | | | | |

## Appendix C
## Transmission Cover Sheet and Quality Control Verification

**Quality Control Verification - FFS** *States are responsible for quality control checking each dataset prior to submitting the data to the SC. These are the minimum required checks. Please provide the name of the person "signing off" on each QC check.*

***By placing your name in this box, you are verifying that your state performed the quality control check and the results have been reviewed and are acceptable.***

| Quality Control Check | Suggested Test or Question to Ask | Your Name |
|---|---|---|
| Data include only Title XIX FFS claims (as defined in the instructions) | How does the program designate a claim as Title XIX or Title XXI? How does the program designate a claim as FFS or managed care? | |
| Data with paid dates from FFY 2011 Q1. | Test dates of service. Are all original paid dates between October 1, 2010 and December 31, 2010? | |
| Data represent only original paid claims. | Are there any adjustments in the data? Are there any negative payments in the data? How does the program isolate only original paid claims? | |
| Each payment is represented in only one universe, and only once in each universe. | Are there any ICN-line combinations across the data and in each dataset that repeat? | |
| State-only paid services are removed from the data. | How does the program eliminate state-only funded services? | |
| Records reflect the smallest independently priced service level, which may be header, line, or fixed payment. | How did the state decide if the sampling unit is the header or the line (e.g., using claim type)? Were there any special instructions for FQHC payments? | |
| Include FFS fixed payments (as defined in the instructions) in data. | Are HIPP, PCCM, and other fixed payments included in the data submission? Were these found in non-MMIS payment systems? | |
| Data do not include gross payments (non-beneficiary specific) to providers. | How does the program eliminate or exclude gross payments? Review the highest paid amounts in the data to be sure they are beneficiary-level payments. | |

## Appendix C
## Transmission Cover Sheet and Quality Control Verification

| Quality Control Check | Suggested Test or Question to Ask | Your Name |
|---|---|---|
| Zero-paid claims and denied claims are included in the data. | Count the number of zero-paid claims and denied claims. Do denied claims ever have payment amounts greater than $0? | |
| All required fields are included and each field is populated with a value. | Review instruction appendix for list of required fields. Are there any missing values for any of the fields? Is the data dictionary for any state-specific fields included? | |

| **Identification of Potential Data Discrepancies or Other Information:** *Please indicate whether there have been any major changes since the last quarter (e.g., introduction of a large managed care program, significant benefit changes or limitations introduced this quarter) that substantially impact the total dollars in the universe or distribution of dollars by claim type, compared to previous quarters. If possible, provide an estimate of the impact of the changes (e.g., 10% decrease in overall FFS spending in Q3). Also, please use this space to share other important information about the data submissions.* |
|---|
| |

**Appendix C**
**Transmission Cover Sheet and Quality Control Verification**

## Medicaid Managed Care, Quarter 1

Complete and submit this cover sheet with every PERM data submission.

| | | | | |
|---|---|---|---|---|
| **State:** | | | | |
| **Date:** | | | | |
| **Quarter:** | | | | |
| **Contact person for data questions** | | | | |
| **Name:** | | | | |
| **Phone:** | | | | |
| **Email:** | | | | |
| **Title:** | | | | |
| **Organization:** | | | | |
| **Data Descriptions** *Complete information below. Please include a row describing the data documentation. Add more rows as necessary.* | | | | |
| **Data Description** (e.g., Q1 Medicaid MC; data documentation) | **Data Filename** | **File Format** (e.g., text, Excel, SAS) | **File Media** (e.g., CD, DVD, FTP) | **Password Protected? (Y/N)** (if yes, send password separately) |
| | | | | |
| (Add rows if necessary) | | | | |

## Appendix C
## Transmission Cover Sheet and Quality Control Verification

**Control Totals** *Add more tables as necessary.***NOTE:** List the lines cont and total $$ by managed care program area, not universe totals. Add more rows as necessary to reflect each claim type.

**Data filename:** 0

| **Month** October | | | **Month** November | | | **Month** December | | |
|---|---|---|---|---|---|---|---|---|
| **Program** | **Total Lines** | **Total $$** | **Program** | **Total Lines** | **Total $$** | **Program** | **Total Lines** | **Total $$** |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| (Add rows if necessary) | | | | | | | | |

**Data filename:** 0

| **Month** October | | | **Month** November | | | **Month** December | | |
|---|---|---|---|---|---|---|---|---|
| **Program** | **Total Lines** | **Total $$** | **Program** | **Total Lines** | **Total $$** | **Program** | **Total Lines** | **Total $$** |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| (Add rows if necessary) | | | | | | | | |

## Appendix C
## Transmission Cover Sheet and Quality Control Verification

**Quality Control Verification - Managed Care** *States are responsible for quality control checking each dataset prior to submitting the data to the SC. These are the minimum required checks. Please provide the name of the person "signing off" on each QC check.*
***By placing your name in this box, you are verifying that your state performed the quality control check and the results have been reviewed and are acceptable.***

| Quality Control Check | Suggested Test or Question to Ask | Your Name |
|---|---|---|
| Data include only Title XIX managed care claims (as defined in the instructions) | How does the program designate a claim as Title XIX or Title XXI? How does the program designate a claim as FFS or managed care? | |
| Data with paid dates from FFY 2011 Q1. | Test dates of service. Are all original paid dates between October 1, 2010 and December 31, 2010? | |
| Data represent only original paid claims. | Are there any adjustments in the data? Are there any negative payments in the data? How did you isolate only original paid claims in the programming? | |
| Each payment is represented in only one universe, and only once in each universe. | Are there any ICN-line combinations across the data and in each dataset that repeat? | |
| State-only paid services are removed from the data. | How does the program eliminate or exclude state-only funded services? | |
| Include maternity kick payments. | Did you include maternity kick payments? What was the data source for these payments? | |
| Include PACE payments. | Did you include PACE capitation payments? What was the data source for these payments? | |
| Data do not include gross payments (non-beneficiary specific) to providers. | How does you program eliminate or exclude gross payments? Review the highest paid amounts in the data to be sure they are beneficiary-level payments. | |

## Appendix C
## Transmission Cover Sheet and Quality Control Verification

| Quality Control Check | Suggested Test or Question to Ask | Your Name |
|---|---|---|
| Zero-paid claims and denied claims are included in the data. | Can managed care claims be denied or zero paid? Count the number of zero-paid claims and denied claims. Can denied claims have payment amounts greater than $0? | |
| All required fields are included and each field is populated with a value. | Review instruction appendix for list of required fields. Are there any missing values for any of the fields? Is the data dictionary for any state-specific fields included? | |
| **Identification of Potential Data Discrepancies or Other Information:** *Please indicate whether there have been any major changes since the last quarter (e.g., introduction of a large managed care program, significant benefit changes or limitations introduced this quarter) that substantially impact the total dollars in the universe or distribution of dollars by claim type, compared to previous quarters. If possible, provide an estimate of the impact of the changes (e.g., 10% decrease in overall FFS spending in Q3). Also, please use this space to share other important information about the data submissions.* | | |
| | | |

**Appendix D**
**PERM Universe/Financial Reports Comparison Results**

**State:** _____

**Program** (check one): ☐Medicaid ☐CHIP

**Universe** (check one): ☐Fee-For Service ☐Managed Care

| | **PERM Universe** | **CMS-64/21** |
|---|---|---|
| **Quarter** | Quarter ___ | Quarter ___ |
| **Total** | $ | $ |

**Explanation for Significant Variances:**

_____
_____
_____
_____

**Conclusion:**

_____
_____

## Appendix E
## Differences Between the FY 2008 and FY 2011 PERM Cycles

### Variable Comparison for Medicaid and CHIP FFS Universe Submission

| | 2008 | 2011 | Change |
|---|---|---|---|
| ICN | required | required | |
| Line number | required | required | |
| Date paid | required | required | |
| Amount paid | required | required | |
| Claim type | required | required | |
| Funding code | | new, required | √ |
| Payment status | required | required | |
| Fixed payment indicator | | new, required | √ |
| Payment level | required | required | |
| Provider ID | | new, required | √ |
| Provider type | required | required | |
| Provider specialty | | new, required | √ |
| Service code | required | required | |
| Source location | | new, required | |
| Place of service | required | no longer required | √ |
| User option fields 1-5 | | new, optional | √ |

### Variable Comparison for Medicaid and CHIP Managed Care Universe Submission

| | 2008 | 2011 | Change |
|---|---|---|---|
| ICN | required | required | |
| Date paid | required | required | |
| Amount paid | required | required | |
| Managed care program indicator | required | required | |
| Payment type | required | required | |
| Funding code | | new, required | √ |
| Provider ID | required | required | |
| Beneficiary ID | required | required | |
| Beneficiary name | required | required | |
| Beneficiary rate indicator | required | required | |
| Beneficiary aid category | required | required | |
| Beneficiary DOB | required | required | |

## Appendix E
## Differences Between the FY 2008 and FY 2011 PERM Cycles

| | 2008 | 2011 | Change |
|---|---|---|---|
| Beneficiary gender | required | required | |
| Beneficiary county | required | required | |
| Service area indicator | required | required | |
| Source location | | new, required | √ |
| Coverage period | required | required | |
| Payment status | required | required | |
| User option fields 1-5 | | new, optional | √ |

### Variable Comparison for Medicaid and CHIP FFS Details Submission

| | 2008 | 2011 | Change |
|---|---|---|---|
| PERM ID | required | required | |
| ICN | required | required | |
| Line number | | new, required | √ |
| PERM state | required | required | |
| Sample year | required | required | |
| Sample quarter | required | required | |
| Claim type | required | required | |
| Payment status | required | required | |
| Medicare crossover indicator | required | required | |
| Amount paid header | required | required | |
| Date paid | required | required | |
| DOS from Clm | required | required | |
| DOS to Clm | required | required | |
| Beneficiary ID | required | required | |
| Beneficiary name | required | required | |
| Beneficiary DOB | required | required | |
| Beneficiary gender | required | required | |
| Beneficiary county | required | required | |
| Billing prov number | required | required | |
| Billing prov name | required | required | |
| Billing prov type | required | required | |
| Billing prov spec | required | required | |
| Billing prov addr 1 | required | required | |

## Appendix E
## Differences Between the FY 2008 and FY 2011 PERM Cycles

| | 2008 | 2011 | Change |
|---|---|---|---|
| Billing prov addr 2 | required | required | |
| Billing prov city | required | required | |
| Billing prov state | required | required | |
| Billing prov zip | required | required | |
| Billing prov phone | required | required | |
| Billing prov fax | required | required | |
| Billing prov NPI | required | required | |
| ICD9 proc code 1 | required | required | |
| ICD9 proc code 2 | required | required | |
| ICD9 proc code 3 | required | required | |
| Diag 1 | required | required | |
| Diag 2 | required | required | |
| Diag 3 | required | required | |
| Diag 4 | required | required | |
| Diag 5 | required | required | |
| DRG | required | required | |
| Source location | required | required | |
| Line item number | required | required | |
| Sampled ind | required | required | |
| Proc code line | required | required | |
| Units paid | required | required | |
| Amount paid line | required | required | |
| Proc mod 1 | required | required | |
| Proc mod 2 | required | required | |
| Rev code | required | required | |
| Perf prov number | required | required | |
| Perf prov name | required | required | |
| Performing prov type | required | required | |
| Peforming prov spec | required | required | |
| Perf prov addr 1 | required | required | |
| Perf prov addr 2 | required | required | |
| Perf prov city | required | required | |
| Perf prov state | required | required | |
| Perf prov zip | required | required | |

## Appendix E
## Differences Between the FY 2008 and FY 2011 PERM Cycles

| | 2008 | 2011 | Change |
|---|---|---|---|
| Perf prov phone | required | required | |
| Perf prov fax | required | required | |
| Perf prov NPI | required | required | |
| DOS from line | required | required | |
| DOS to line | required | required | |
| POS | required | required | |
| TOS | required | required | |
| NDC code | required | required | |
| Drug order date | required | required | |
| Prescription number | required | required | |
| Prior authorization | required | required | |
| Date paid line | required | required | |
| Claim category fields | required | required | |
| Adjustment fields | required | no longer required | √ |
| Adjustment date | required | no longer required | √ |
| User fields 1-5 | optional | optional | |
| Sampling unit level | required | no longer required | √ |
| Historical ICN | required | no longer required | √ |
| Original state ICN | required | no longer required | √ |
| Claim category | required | no longer required | √ |
| Adj indicator | required | no longer required | √ |
| Number of line items | required | no longer required | √ |
| Rev code description | required | no longer required | √ |