



FY 2016 PERM+ Data Submission Instructions

September 30, 2015

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1.0 Section 1: Overview

The Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act, or IPERA) requires the heads of federal agencies to annually review programs they administer and identify those that may be susceptible to significant improper payments, to estimate the amount of improper payments, to submit those estimates to Congress, and to submit a report on actions the agency is taking to reduce the improper payments. IPERA was amended by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012, which emphasizes the importance of not only measuring improper payments, but also recovering and reducing improper payments. The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. As a result, CMS developed the Payment Error Rate Measurement (PERM) program to comply with the IPIA and related guidance issued by OMB.

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review.¹

To compute the PERM error rates, all of the Medicaid and CHIP claims that were paid or denied during the annual period being evaluated are submitted by each state to the Statistical Contractor (SC) under contract with CMS to develop the PERM error rates. 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 recipient-specific payments and many aggregate payments (together referred to as the PERM "universe"), as well as recipient and provider information for claims that are sampled for review.

These instructions are intended to guide state staff in the preparation of the claims data that they will have to provide to support to the PERM SC. The instructions include information about PERM program areas that are used to compute PERM measures, data sources, required variables, state quality control checks, and data submission security requirements. Appendices include tables of required fields, a Transmission Cover Sheet for quality control verification, and specific differences between the FY 2013 and FY 2016 PERM cycles.

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

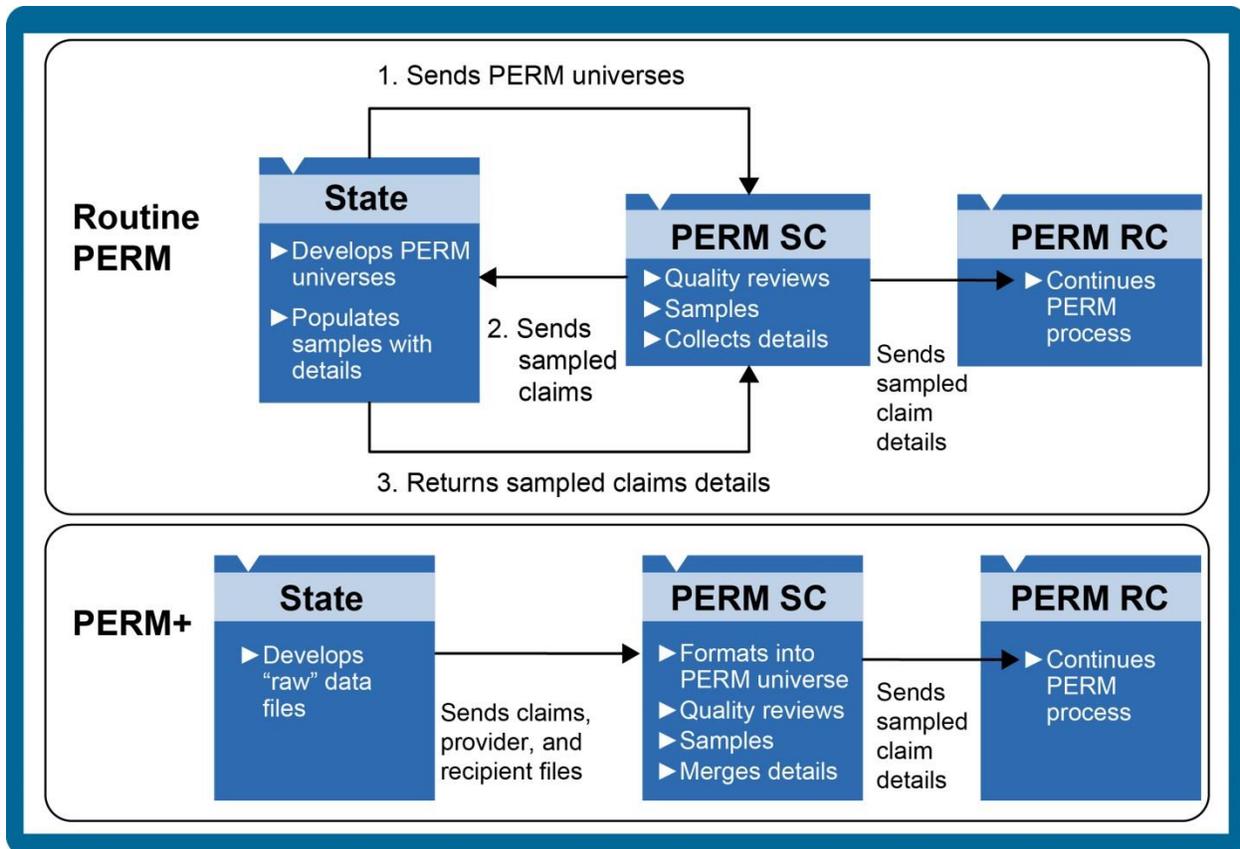
1.1 PERM+

PERM+ is an innovative way for states, CMS, and the CMS PERM contractors to approach data submission for the claims and payments portion of PERM. PERM+ simplifies the PERM data submission process for the states, as claim, recipient, and provider data are submitted

¹ The FY 2016 PERM cycle will not include an eligibility component review. See State Health Official Letter #13-005 at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-005.pdf>

simultaneously, eliminating the need for states to submit additional information prior to requesting medical records. Exhibit 1 compares data flow for routine PERM and PERM+.

Exhibit 1: Data Flow in Routine PERM and PERM+



PERM+ generally requires less upfront analysis and data modifications by the state because the PERM SC, not the state, will be responsible for assigning and extracting data as “sampling units” (e.g., figuring out if a claim or payment should be sampled at the header or line level based on the payment methodology, and removing records that do not qualify for sampling) and dividing the PERM+ data submissions into fee-for-service and managed care datasets for sampling. However, state assistance is necessary for the SC to understand the data and accurately build universes that meet PERM requirements. In early quarters, the amount of assistance needed may be higher so the state and SC may communicate specifications while acclimating to PERM needs.

1.2 Initial Preparations for PERM+

Developing PERM universes is a collaborative process between the states, CMS, and the 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 their 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 both state and vendor staff with expertise in areas such as:

Program structure: Includes staff from the single state agency and other designated state agencies who are responsible for and knowledgeable of:

- ▶ Medicaid and CHIP program administration, development of state regulations and policies, and coordination across the organization(s)
- ▶ Managed care program design, contract administration and oversight, and quality measurement
- ▶ Reimbursement policies for state plan services, rate development for at-risk and/or partial risk contracts, and cost reconciliation arrangements
- ▶ Claims, billing, and payment mechanisms for all federally matched Title XIX and XXI services
- ▶ State-only funded programs adjudicated in MMIS

Data sources: Includes state staff and contractors responsible for the implementation and ongoing support of:

- ▶ The state's Medicaid Management Information System (MMIS) and any Third Party Administrator (TPA)
- ▶ Health insurance premium payment (HIP) program and payments
- ▶ Pharmacy Benefit Manager (PBM)
- ▶ Other state agencies, systems, and vendors responsible for claims, payments, adjudications, or data warehousing

Technical aspects of claims adjudication: Includes staff knowledgeable of data components and processing, including:

- ▶ Definition of paid date
- ▶ Treatment of adjustments, denied/voided/rejected claims

Field selection: Includes staff who can apply PERM requirements to identify necessary fields that indicate certain considerations for PERM, including:

- ▶ Services matched with certified public expenditures (CPEs) and the amount
- ▶ Co-pays and Third Party Liability (TPL)
- ▶ Original paid date

Budget and finance: Includes staff who are responsible for developing and submitting federal matching fund reports (e.g., quarterly CMS-64 and CMS-21 reports)

1.3 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 15, 2015) and the error rate calculation occurring at the end of the review cycle.

Exhibit 2 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 the development of the claims, provider, and recipient files for PERM+ as early as possible in the cycle. States should expect to spend time in the first quarter (Q1) of the fiscal year of the measurement (October through December 2015) 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 and resolving any data issues found during data validation and quality control. Subsequent data submissions are due in April, July, and October.

Exhibit 2: FY 2016 PERM+ Data Submission Timeline

Date	State Activities	SC/CMS Activities
<i>August 2015</i>	<ul style="list-style-type: none"> ▶ Determine if the state will submit via PERM+ or routine PERM ▶ Select PERM team ▶ Provide completed Universe Data Submission Survey and data dictionaries 	<ul style="list-style-type: none"> ▶ Meet with select states to discuss the PERM+ submission option ▶ Answer questions about PERM+ ▶ Send final component sample sizes to each state
<i>September 2015</i>	<ul style="list-style-type: none"> ▶ Schedule state Intake Meeting ▶ Participate in PERM 101 Education sessions 	<ul style="list-style-type: none"> ▶ Organize state Intake Meeting
<i>October - December 2015</i>	<ul style="list-style-type: none"> ▶ Participate in a state Intake Meeting ▶ Review and update notes from Intake Meeting ▶ Review Data Submission Instructions ▶ Participate in Data Submission Overview Meeting ▶ Participate in CMS 64/21 comparison process overview meeting ▶ Ask questions and provide feedback ▶ Test SC secure file transfer site 	<ul style="list-style-type: none"> ▶ Participate in state Intake Meeting ▶ Answer questions from and provide feedback to PERM+ states

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Date	State Activities	SC/CMS Activities
December 2015	<ul style="list-style-type: none"> ▶ Code programs to provide PERM+ data sets ▶ Conduct quality control (QC) review of PERM data to ensure its compliance with requirements ▶ Ask questions and provide feedback 	<ul style="list-style-type: none"> ▶ Answer questions from and provide feedback to PERM+ states
January 15, 2015	<ul style="list-style-type: none"> ▶ Submit Q1 PERM+ data to the SC 	<ul style="list-style-type: none"> ▶ Receive Q1 PERM+ data from states
January 15 – February 2016	<ul style="list-style-type: none"> ▶ Work with SC to revise FFS strata mapping ▶ Work with SC to resolve issues identified during the data validation and QC Process ▶ Review SC plans to build PERM universes 	<ul style="list-style-type: none"> ▶ Review FFS strata mapping ▶ Begin SC data validation and QC Process ▶ Receive state approval for plans to build PERM universes ▶ Build PERM universes
March-April 2016	<ul style="list-style-type: none"> ▶ Work with SC to resolve issues identified QC of PERM universes 	<ul style="list-style-type: none"> ▶ Perform QC review of PERM universes ▶ Select Q1 samples
Within 30 days after sampling	<ul style="list-style-type: none"> ▶ Work with SC to resolve issues with PERM details data 	<ul style="list-style-type: none"> ▶ Build and format Q1 PERM details submissions ▶ Transmit formatted details to the RC
April 15, 2016	<ul style="list-style-type: none"> ▶ Submit Q2 PERM+ data to the SC 	<ul style="list-style-type: none"> ▶ Receive Q2 PERM+ data from states
April 15 – June 2016	<ul style="list-style-type: none"> ▶ Work with SC to resolve issues identified during the QC of PERM universes 	<ul style="list-style-type: none"> ▶ Build PERM universes ▶ Perform QC review of PERM universes ▶ Select Q2 samples
Within 30 days after sampling	<ul style="list-style-type: none"> ▶ Work with SC to resolve issues with PERM details data 	<ul style="list-style-type: none"> ▶ Build and format Q2 PERM details submissions ▶ Transmit formatted details to the RC
July 15, 2016	<ul style="list-style-type: none"> ▶ Submit Q3 PERM+ data to the SC 	<ul style="list-style-type: none"> ▶ Receive Q3 PERM+ data from states
July 15 – September 2016	<ul style="list-style-type: none"> ▶ Work with SC to resolve issues identified QC of PERM universes ▶ Review CMS-64/21 analysis and provide feedback to the SC as necessary 	<ul style="list-style-type: none"> ▶ Build PERM universes ▶ Perform QC review of PERM universes ▶ Select Q3 samples ▶ Conduct CMS-64/21 comparison and analysis

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Date	State Activities	SC/CMS Activities
<i>Within 30 days after sampling</i>	<ul style="list-style-type: none"> ▶ Work with SC to resolve issues with PERM details data 	<ul style="list-style-type: none"> ▶ Build and format Q3 PERM details submissions ▶ Transmit formatted details to the RC
<i>October 17, 2016</i>	<ul style="list-style-type: none"> ▶ Submit Q4 PERM+ data to the SC 	<ul style="list-style-type: none"> ▶ Receive Q4 PERM+ data from states
<i>October 15 – December, 2016</i>	<ul style="list-style-type: none"> ▶ Work with SC to resolve issues identified during the QC of PERM universes 	<ul style="list-style-type: none"> ▶ Build PERM universes ▶ Perform QC review of PERM universes ▶ Select Q4 samples
<i>Within 30 days after sampling</i>	<ul style="list-style-type: none"> ▶ Work with SC to resolve issues with PERM details data 	<ul style="list-style-type: none"> ▶ Build and format Q4 PERM details submissions ▶ Transmit formatted details to the RC

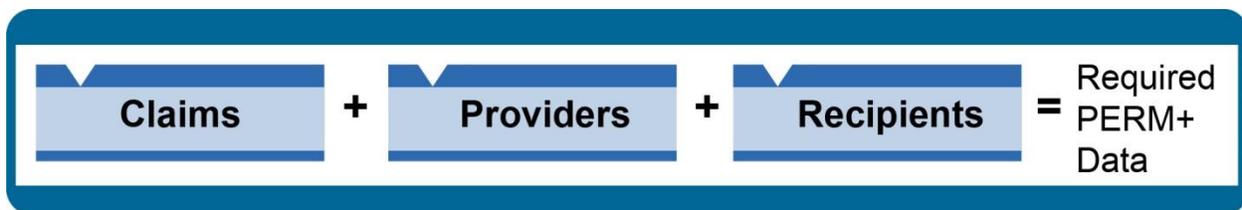
2.0 Section 2: PERM+ Data File Specifications

This section addresses the content of the PERM+ data submissions, including the structure of the submission, PERM payment inclusions and exclusions, and descriptions of the required fields along with requirements for those fields

2.1 File Structure

For PERM+, the states submit data files to the SC containing all fields required for sampling, data processing review, and medical record request and review (see Exhibit 3). States submit PERM+ data in three files: claim information, recipient information, and provider information.

Exhibit 3: Claims, Provider, and Recipient Data are Required for PERM+ Submissions



Claim Header and Claim Detail Files

Generally, states include in the PERM+ data submission all recipient-level Medicaid and CHIP claims and payments that are matched with either federal Title XIX or Title XXI funds. Additionally, states may also make payments in aggregate based on recipient-level information. States and the SC will work together to determine a plan for submitting aggregate payments.

PERM+ offers states flexibility in the structure of the data files submitted to the SC. PERM+ states may submit one file with claim headers and a second file with claim details, submit one file with both claim header and detail data, or submit data using another combination (e.g., institutional and practitioner claims in separate files). The SC will work with the state to determine the most appropriate file structure.

Recipient and Provider Files

The PERM Review Contractor (RC) requires recipient and provider information for sampled claims to request medical records from providers and to conduct the medical and data processing reviews. Therefore, states submit recipient information (e.g., name, date of birth) and provider information (e.g., address, provider type) as separate files in the PERM+ submissions. For each sampled claim, the SC will use the recipient and provider numbers to “match” to the recipient and provider information in the separate files.

When developing the provider file, states should include all available provider records regardless of the provider’s status as an active or inactive provider. States should also include all providers – billing, performing (servicing/rendering/attending) and referring (prescribing) – in the provider file. When developing the recipient file, states should include recipient records for all recipients who have a claim in the PERM claims file. The SC will work with states to satisfy these requirements for the provider file and the recipient file.

2.2 Universe Parameters

The PERM+ data submission is primarily defined by three major parameters that have PERM-specific definitions, each of which is described in more detail below:

- ▶ Program Type
- ▶ Date
- ▶ Paid Amount

This section defines and discusses three primary PERM universe parameters as well as provides guidance on other areas that are critical to the submission of a complete and accurate PERM universe including: the treatment of denied and zero-paid claims; payments and records excluded from PERM; and PERM data sources.

Program Type

Generally, states include in their PERM+ data submissions all recipient-level claims and payments and certain aggregate payments for services provided to individual recipients for which the state receives federal financial participation (FFP) through Title XIX or Title XXI (limited exclusions are discussed in a later section). Identification of Medicaid and CHIP and the division between FFS and managed care is discussed further in the following sections.

Identifying Medicaid and CHIP

States must include both Title XIX and Title XXI matched payments in their PERM+ data submissions. As CMS must report separate error rates for the Medicaid and CHIP programs, the SC will assign claims in the PERM+ data submission to either Medicaid or CHIP universe. States are required to populate the field “Medicaid/CHIP Indicator” in the claims file (Appendix A) to categorize each claim or payment as either Medicaid or CHIP. States should assign claims to Medicaid or CHIP based on:

- 1) **Source of federal money, not the program design.** Payments for Medicaid expansion-type CHIP programs or Medicaid expansion groups that are matched by Title XXI FFP should be identified as CHIP claims or payments. States with both Medicaid-expansion type CHIP and stand-alone CHIP should identify claims and payments for both programs as CHIP in the Medicaid/CHIP Indicator field.
- 2) The recipient’s eligibility status during the dates of service at the time the claim was paid (adjudicated), not the recipient’s eligibility status at the time the state selects the data for PERM.

Include in the PERM+ claims file as **Medicaid** claims:

- ▶ All payments that are paid for in whole or in part by Title XIX federal financial participation (FFP) dollars,
- ▶ Payments considered for Title XIX dollars but denied
- ▶ Use a Medicaid/CHIP Indicator of “1” to show that a claim or payment is Medicaid (Title XIX). (See [Appendix A](#) for reference.)

Include in the PERM+ claims file as **CHIP** claims:

- ▶ All Medicaid expansion and/or stand-alone CHIP payments
- ▶ Payments that are paid for in whole or in part by Title XXI dollars, as well as payments submitted as Title XXI services but denied
- ▶ Use a Medicaid/CHIP Indicator of “2” to show a claim or payment is CHIP (Title XXI). (See [Appendix A](#) for reference.)

Appendix A also includes a field called “State 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. **If your state has difficulty distinguishing between Title XIX and Title XXI payments, please notify the SC who will work with state staff to find an appropriate solution.**

Identifying Fee-for-Service and Managed Care for PERM

In addition to separately measuring Medicaid (Title XIX) and CHIP (Title XXI), PERM also independently measures fee-for-service (FFS) and managed care, as applicable, for each state. Referred to as “component” measurements, FFS and managed care have PERM-specific definitions which may differ from how states define each mode of service delivery. Further, PERM also has additional inclusion rules that are necessary to ensure a complete and accurate PERM universe. Below is an overview of how PERM defines each “component” as well as information on what types of records are included in each “component” universe.

During each state’s intake discussion, the SC will discuss these component definitions in more detail with the state to ensure that data provided is consistent and compliant with PERM guidance as well as to support the state in determining where specific payments should be assigned for PERM purposes.

Fee-for-Service Universe

The PERM FFS universe includes three primary types of Medicaid and CHIP payments.

1.) Traditional fee-for-service claims

The FFS universe is comprised of all payments made on a fee-for-service/indemnity basis, including:

- ▶ Traditional fee-for-service payments to physicians, hospitals, pharmacies, home health agencies, long-term care (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

2.) Capitated non-risk payments

In addition to “traditional” FFS payments, the PERM FFS universe also includes other types of payments referred to as “fixed” for PERM purposes. These payments are often capitated, per-member per-month payments and could be system-generated, non-medical, and/or

administrative-like payments that would not require a PERM medical record review like other PERM FFS payments. These payments are not considered to be “at risk” like managed care payments (defined in the Managed Care Universe section, below). Examples of PERM “fixed” payments include a variety of payments made to providers or vendors such as:

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

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 FFS universe.

3.) Aggregate payments

While most Medicaid and CHIP payments for services are paid at the recipient level, states may calculate and pay for some services on behalf of a group of recipients. When these payments are made for a group of recipients and individual payment records are not readily available or cannot easily be re-created, PERM classifies these as “aggregate payments.” Unless otherwise specified by CMS, all payments for services to recipients 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. The SC will work with the state to determine whether certain payments should be classified as “aggregate payments” for the purposes of PERM.

Examples of aggregate payments include:

- ▶ Reimbursement to counties for non-emergency transportation services provided to all Medicaid recipients residing in that county;
- ▶ Contractual payment to a broker for services (e.g. transportation) that cannot be identified at the recipient level; and
- ▶ Fees paid to a case management vendor based on the number of recipients 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. It is critical that states raise all possible aggregate payments to CMS and the SC for discussion so that all payments required for PERM review are included in a universe.

*All payments identified by the state as possibly being aggregate **must** be discussed with the SC before a determination is made.*

4.) Other Payments

In addition to the three primary types of payments, there may be other types of payments that states need to submit as part of the PERM universe. There are many states with new programs that make supplemental or 'bump' payments for certain types of services. Examples of these payments include difficulty of care payments made to ICF/MRs for recipients with developmental disabilities, 1202 'bump' payments made to primary care physicians, and health home incentive payments. These are usually small dollar payments that can be tied to individual recipients and services. In rare instances these payments are made to providers on the aggregate level. Not all incentive payments meet the requirements for inclusion in the PERM universe. For example, pay-for-performance payments are excluded. If your state makes any supplemental payments to providers, you should notify the SC and explain in what types of situations these payments are made and on what basis. A determination can be made at that point as to whether or not the claims need to be submitted as part of the PERM universe.

Managed Care Universe

Managed care payments are typically at-risk capitation payments. These include:

- ▶ Premiums for "full risk" indemnity insurance, such as payments to Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs), Pre-paid Inpatient Hospital Plans (PIHPs), and Health Insurance Organizations (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 recipients (e.g., at-risk payments for services provided to people living with HIV/AIDS)
- ▶ Certain non-capitated, recipient-specific payments made to managed care organizations such as newborn 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 (see [Capitated Non-Risk Payments](#), above). The SC will work with each state to evaluate state programs and determine if program payments conform to the PERM managed care definition or if the payments should be included in the fee-for-service universe instead.

Date

PERM universes include claims and payments originally paid during the federal fiscal year under review. 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.

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- ▶ 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 based on the original paid date.

For the FY 2016 PERM cycle, the state's PERM universe includes claims and payments with original dates of payment between October 1, 2015 and September 30, 2016.

States submit PERM+ data quarterly, including all claims with an original date of payment within the federal fiscal quarter. Data are due to the SC **15 days after the end of each quarter**. See [Exhibit 4](#) for the data submission due dates for FY 2016 and the paid claim dates to be included in each quarterly submission.

Exhibit 4: Federal Fiscal Quarters and PERM Data Submission Dates, FY 2016

FY 2016 Quarter	Claim Date Paid	Data Submission Due
Quarter 1	October 1 – December 31, 2015	January 15, 2016
Quarter 2	January 1 – March 31, 2016	April 15, 2016
Quarter 3	April 1 – June 30, 2015	July 15, 2016
Quarter 4	July 1 – September 30, 2016	October 15, 2016

States may submit the adjudication date instead of the original paid date in the PERM universe as long as the state maintains a consistent date approach throughout all four quarterly submissions. The **adjudication date** refers to the date that a claim is fully processed and either approved for payment or denied.

States may also submit certain types of claims (for example, off-MMIS claims) using a date approach that is different from the other universe claims, as long as the dates for each data set submitted for those claims are consistent over the course of the year. For example, a state could submit all MMIS claims using adjudication date but submit all off-MMIS HIPP payments using paid date.

The SC will review the dates that are included for each data source with the state at the beginning of the cycle and will work with the state to identify the best date field for determining the PERM universe for each quarter.

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). Managed care capitation payments should be included in the PERM+ data submission based on paid date as well.

- ▶ **Prospective example:** A state makes a capitation payment on December 25, 2015 for services in January 2016. The state includes the payment with the PERM Q1 data submission.
- ▶ **Retrospective example:** A state makes a capitation payment on October 5, 2015 for services in September 2015. The state should include the payment with the PERM Q1 data submission.

Paid Amount

The paid amount for each claim and payment in PERM should reflect the original, non-adjusted total computable paid amount. The **total computable paid amount** is the federal share plus the state and/or local share of the payment.

The total computable paid amount should not include recipient cost sharing amounts, such as patient liability (co-pays, contribution to care), third party liability (TPL), or any other non-Title XIX or Title XXI matched dollars (e.g., taxes paid on waiver services).

For certified public expenditures (CPEs) such as school-based services or payments to public hospitals, the state must provide both the federal and state/local share for the PERM paid amount even if the paid amount in the payment system only reflects the federal share for which match is claimed. Please discuss any CPEs or other payments with the SC where the paid amount in the state's payment system might not reflect the PERM-defined total computable paid amount.

2.3 Additional PERM Universe Specifications

In addition to the three main parameters identified above, PERM universes must also meet additional specifications.

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+ data submission. Denied claims from vendor payment systems must be included in the PERM+ data submission if the claims are program claims that are not found in the state MMIS. In certain 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 recipient identifier). Please discuss the 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 spend-down recipients who have not met their financial obligations. Include zero-paid claims in the PERM+ data submission.

Service Expenditures Matched at the Administrative Rate

PERM includes payments made for medical services received by individual recipients that are matched either at the medical federal medical assistance percentage (FMAP) or that receive federal financial participation (FFP) as an allowable administrative cost. The most common medical services that may be matched with administrative funds include non-emergency transportation or health insurance premium program (HIPP) payments. Please discuss with the SC any services that are considered an allowable administrative cost, but could be considered a medical service to determine if the service payments should be reported for PERM.

Claims and Payments Excluded from the PERM Universe

Below we provide some specific guidance regarding what types of payments, claims, and records are excluded from the PERM universe. Certain 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. During the intake meeting, the SC will discuss these exclusions in more detail with each state to ensure that each state's specific data submission is compliant with PERM requirements regarding excluded data.

Payments Excluded by Regulation

The PERM regulation explicitly excludes a small number of specific payment types from the universe, when not paid at the individual recipient-level.²

² States may include these in the PERM+ submissions if the payments are readily identifiable and the state instructs the SC to remove the payments prior to sampling.

- ▶ 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
- ▶ Mass adjustments

State-only and Other Non-Title XIX /Non-Title XXI Payments

Not all claims processed in MMIS are matched with Title XIX or Title XXI funds. Only claims and payments matched with federal funds are included in PERM. PERM+ states may include state-only claims and payments in the PERM+ submissions, however in that case, the states should provide documentation and guidance that will allow the SC to exclude these from the PERM universes.

Medicare Part A and Part B Premium Payments

States should not include Medicare Part A and Part B premium payments 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 their PERM submissions. For PERM purposes, encounter data are 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 recipient-specific, encounters do not represent an actual payment made by the state.

Rejected Claims

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. PERM+ states may include rejected claims in the PERM+ submissions; however in that case, the states should provide documentation and guidance that will allow the SC to exclude these from the PERM universes.

Payments for administrative functions

As noted above, PERM claims and payments represent services to recipients. 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. For cases in which a state blends dollars for recipient services with administrative payments into a single reimbursement rate, the state should submit the entire payment for PERM review.

Adjusted Claims

Only original claims and payments are included in PERM. PERM+ states may include state-only claims and payments in the PERM+ submissions, however in that case, the states should provide documentation and guidance that will allow the SC to exclude these from the PERM universes.

2.4 Data Sources

States generally extract 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)
- ▶ Services for individuals with mental retardation or developmental disabilities (MR/DD)
- ▶ 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

State staff should “follow the money” by reviewing their state’s federal financial reports to determine if a state is capturing payments from all of the data sources. 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.

2.5 Sampling Units in the PERM+ Submission

There is much emphasis on states submitting PERM data at the correct “sampling unit” (i.e., states submit at the header or line based on how the claim is priced and paid) in Routine PERM. However for PERM+, the SC, not the state, is responsible for establishing the correct sampling unit for each claim or payment.

States need to submit both header and detail/line records for all claims for PERM+. States also need to provide guidance to help the SC identify header and detail records in the claims submission. **Submitting all of the header and detail information for a claim is a key difference between the PERM+ data submission and the routine PERM data submission.**

The SC will discuss with states the various claims payments to understand how different types of claims are adjudicated and paid. The SC will then use the claims and payment data and guidance from the state to develop the PERM sampling units.

2.6 Identifying Services Types for Sampling Stratification

For FY 2016, the SC will continue to use the approach to stratification that was implemented in FY 2013. The fee-for-service (FFS) universe is stratified by a hybrid approach of service-based strata and dollar-weighted strata prior to sampling. The managed care universe will continue to be stratified by payment amount only. The SC will assign each payment in the FFS PERM to one of four service based strata (updated from FY 2013), which include the following:

- ▶ **Home- and Community-Based Services, Rehabilitation, and Hospice (Medicaid and CHIP)** – Stratum includes long-term care support services provided to members in the community, hospice services, and services provided by rehabilitation centers on an outpatient basis. Claims submitted by the following claim/provider types are included:
 - ▶ Home health agencies
 - ▶ Hospices
 - ▶ Waiver services
 - ▶ Assisted living
 - ▶ Home delivered meals
 - ▶ Personal care
 - ▶ Attendant care
 - ▶ Rehabilitation center services billed on an outpatient or medical claim type

The count of sampled claims from this stratum will be 4 claims at a minimum for each quarter.

- ▶ **Physician, Dentists, and Other Practitioners (MEDICAID and CHIP)** – Stratum includes medical services provided by physicians and other health care professionals, outside of a clinic setting. Claims submitted by the following claim/provider types are included:
 - ▶ Primary care physicians

- ▶ Specialty physicians
- ▶ Psychiatrists and mental health providers
- ▶ Dentists
- ▶ Physician assistants and nurse practitioners
- ▶ Optometrists and opticians
- ▶ Other licensed health care professionals

The count of sampled claims from this stratum will be 4 claims at a minimum for each quarter.

- ▶ **Pharmacy (MEDICAID and CHIP)** – Stratum includes prescription drugs and other medical supplies dispensed by pharmacies in the community. Claims submitted by the following claim/provider types are included:
 - ▶ Independent pharmacies

The count of sampled claims from this stratum will be 4 claims at a minimum for each quarter.

- ▶ **Long-Term Care (MEDICAID ONLY)** – Stratum includes long-term care services and rehabilitation services provided to members at long-term care institutions. Claims submitted by the following claim/provider types are included:
 - ▶ Nursing home facilities
 - ▶ Intermediate care facilities – MR
 - ▶ Rehabilitation hospitals
 - ▶ Residential treatment centers

The count of sampled claims from this stratum will be 4 claims at a minimum for each quarter.

- ▶ **Inpatient Hospital (CHIP ONLY)** – Stratum includes claims for services provided to members on an inpatient basis. Claims submitted by the following claim/provider types are included in this category:
 - ▶ Short-term general hospitals
 - ▶ Psychiatric hospitals
 - ▶ Alcohol and substance abuse hospitals
 - ▶ The physician cost component of inpatient hospital services, when the services were billed on an inpatient claim type

The count of sampled claims from this stratum will be 4 claims at a minimum for each quarter.

All claims that do not fall into one of these service-based strata will be sampled from three dollar-weighted strata. All denied and zero paid claims will be sampled from a separate stratum.

The SC will assign each FFS payment into a service-based stratum using claim-specific information, including such fields as provider type, claim type, place of service, and category of service. However, the combination of fields necessary to categorize claims into service types may vary for certain services, so the SC will need to work with the state to ensure all FFS payments can be accurately mapped to the correct strata.

3.0 Section 3: Changes to the FY 2016 PERM Plus Data Submission Instructions from FY 2013

There has been one update to the required fields since the FY 2013 cycle. A new field has been added in the claims file layout for indicating if a diagnosis code is ICD version 9 or 10. The ICD-10 implementation begins with dates of service on or after October 1, 2015. Since Lewin realizes that the submissions for each quarter may contain a wide range of service dates, we are asking providers to indicate whether a diagnosis code is an ICD-9 or ICD-10 version. Please refer to Appendix A in this document for the location of the field and the appropriate values with which to populate it. This information will be needed by the RC during the medical record review process.

4.0 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, 6, and 7 contain suggested minimal quality control checks for states to complete.

Exhibit 5: Minimum Claims File Quality Control Checks

Quality Review	Suggested Tests
1) Ensure all required fields are reported in the claims file(s)	<ul style="list-style-type: none"> ▶ Prepare a list of all fields in the state’s claims file and compare it to the list of fields for the claims file in Appendix A ▶ Identify any missing fields ▶ 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 and have valid values	<ul style="list-style-type: none"> ▶ Check that key fields are not truncated or contain extra data. Review fields such as: <ul style="list-style-type: none"> <input type="checkbox"/> ICN <input type="checkbox"/> Line Item Number <input type="checkbox"/> Billing Provider Number <input type="checkbox"/> Recipient ID <input type="checkbox"/> Total Computable Amount Paid Header <input type="checkbox"/> Total Computable Amount Paid Line <input type="checkbox"/> Dates of payment
3) Check that the dates of payment for all records are within the appropriate quarter in FY 2016	<ul style="list-style-type: none"> ▶ Only include payments that were adjudicated in the appropriate quarter of FY 2016
4) Confirm that the SC can identify claims as Medicaid (Title XIX) or CHIP (Title XXI)	<ul style="list-style-type: none"> ▶ Confirm that data are present and documentation is available that would allow the SC to assign claims to Medicaid or CHIP PERM universes
5) Confirm that the SC can identify claims as Fee-for-Service or Managed Care	<ul style="list-style-type: none"> ▶ Confirm that data are present and documentation is available that would allow the SC to assign claims to fee-for-service or managed care universes
6) Check that the following payment records can be identified by the SC: <ul style="list-style-type: none"> <input type="checkbox"/> Adjustments and voids <input type="checkbox"/> State-only claims <input type="checkbox"/> Administrative payments <input type="checkbox"/> Gross adjustments <input type="checkbox"/> Claims matched with funds other than Title XIX or Title XXI 	<ul style="list-style-type: none"> ▶ Confirm that data are present and documentation is available that would allow the SC to identify and remove these records

Quality Review	Suggested Tests
7) Each payment is represented only one time in the claims file	<ul style="list-style-type: none"> ▶ Confirm there are no ICN-line number combination is repeated in the claims file
8) Confirm that no encounter claims data is submitted in the claims file	<ul style="list-style-type: none"> ▶ Remove all encounter records
9) Prepare to review the SC's comparison of the CMS-64/21 reports to the PERM universe submissions	<ul style="list-style-type: none"> ▶ Compare PERM universe totals to either two previous quarters' CMS-64/21 reports, or to the current quarter's CMS-64/21 reports ▶ Look for major dips or spikes or "significant" differences

Exhibit 6: Minimum Recipient File Quality Control Checks

Quality Control Check	Suggested Tests
1) Make sure all required fields are reported in the recipient file	<ul style="list-style-type: none"> ▶ Prepare a list of all fields in the state's recipient file and compare it to the list for the recipient file in Appendix B ▶ Identify any missing fields ▶ 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 the Recipient Number field is properly formatted	<ul style="list-style-type: none"> ▶ Check that the Recipient ID field is not truncated or has additional data ▶ Replace the data in the Recipient ID field if formatting problems are found

Exhibit 7: Minimum Provider File Quality Control Checks

Quality Control Check	Suggested Tests
1) Make sure all required fields are reported in the provider file	<ul style="list-style-type: none"> ▶ Prepare a list of all fields in the state's provider file and compare it to the list for the provider file in Appendix C ▶ Identify any missing fields ▶ 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	<ul style="list-style-type: none"> ▶ Check that the Provider Number or the Provider NPI field is not truncated or has additional data depending on which field the state uses to identify providers ▶ Replace the data in the Provider Number or the Provider NPI field if formatting problems are found ▶ Include all billing, performing, and referring providers in the file

4.1 CMS-64 and CMS-21 Report Comparison to PERM Universe Data

States should compare their PERM+ data submissions to CMS-64 and CMS-21 Financial Reports, respectively, to ensure that the universes are complete and accurate. Comparing the PERM+ 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 the PERM+ data and that the state is capturing all necessary data sources in the PERM+ data submission. The CMS-64 and CMS-21 forms may not be finalized until after the PERM+ data are submitted, so we ask that states conduct these comparisons after the forms are finalized. The state should confirm that no programs that appear on the CMS Financial Reports have been omitted from the PERM+ data. If after this comparison the state identifies Medicaid or CHIP dollars that were excluded from the PERM+ data, the state should notify the SC to coordinate the submission of the missing data.

This comparison is separate from the in-depth comparison that the SC will conduct throughout the cycle. The SC will 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 FFS and managed care. If significant differences, as defined by CMS, between PERM universes and the Financial Reports are identified, the SC will contact the state to resolve the differences.

5.0 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.

5.1 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). SFTP instructions will be sent to the states before the first required data submission. Any files sent via SFTP need to be encrypted and password protected. If submission via SFTP is not an option, states may submit data on an encrypted CD or DVD. **Do not send PERM data via email.**

States planning to use the SFTP will be required to test their access prior to the first data submission.

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

5.2 Submission Formats

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

- ▶ **SAS data set:** PC-based SAS data set
- ▶ **Delimited file:** Comma delimited (.csv) or delimited (pipe, tab, etc.) 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.

5.3 Transmission Cover Sheet

The state must submit a Transmission Cover Sheet with every data submission. The Transmission Cover Sheet is used to ensure that all the data sent by the state is received by the SC, and to compare the control totals and to correct any potential data transmission errors before processing and sampling the data. Examples of the Medicaid fee-for-service and Medicaid managed care data Transmission Cover Sheets are provided in [Appendix B](#). The state may include 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 the SFTP. SC will not process the data further until the control totals match.

5.4 File Layouts

States are required to submit file layouts to inform the SC of the field name, length, and type (numeric versus character), and valid values as applicable. File layouts are especially useful to the SC when reading the state's quarterly data submissions.

5.5 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. Data that include protected health information (PHI) and/or personally identifiable information (PII), such as recipient ID numbers, is considered sensitive data.

5.6 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:

- 3) Contact the SC to discuss the SFTP site, establish an SFTP connection, and test the SFTP prior to data submission
- 4) Encrypt and password-protect data files
- 5) Zip all PERM data files, including the Transmission Cover Sheet and file layouts, into a single zip file
 - ▶ Note: For very large files, more than one zip file may be necessary. Additionally, states with very large files may use third-party software to transmit data. Contact the SC for more information.
- 6) Upload the zipped file to the SFTP
- 7) 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:

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

6.0 Appendices

6.1 Fields for PERM+

Appendices A, B, and C list the fields for states to include with the PERM+ data submissions. PERM+ data submissions include provider, recipient, and full claim detail information. States do not need to submit “detail” information after claim sampling. However, this does require the inclusion of more fields in the PERM+ data submission—similar to the field requirements in the routine PERM detail submission.

The data fields to include in each PERM+ file are described in the following appendices:

- ▶ [Appendix A](#): Claims File
- ▶ [Appendix B](#): Recipient File
- ▶ [Appendix C](#): Provider File

6.2 PERM+ Transmission Cover Sheets

Appendix D shows copies of the Transmission Cover Sheets that states should use when submitting files for PERM+. There are separate cover sheets for the claims file, recipient file, and provider file. State should use copies of these transmission cover sheets to report the control totals for each file for each quarter of data submitted for PERM+.

6.3 Appendix A—Claims File Fields

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
ICN	icn	Unique claim identifier (e.g., ICN, TCN, other state issued number)	YES	YES	varchar	<p>Ensure the field is not truncated and does not contain extra data</p> <p>Each record in the Claims File must be able to be uniquely identified with data elements contained in the record, typically a combination of ICN and Line Number</p> <p>If the ICN/Line Number is not sufficient to uniquely identify a claim, the state must identify fields that can be used to uniquely identify a claim</p>
ICN Former	icn_former	For adjustment claims, the state-assigned internal control number (ICN) or transaction control number	YES	Yes		

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		(TCN) of the claim that the current claim is adjusting				
Claim type	clm_type	State claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim	Yes	Yes	varchar	State-specific values
Medicaid/CHIP Indicator	medicaid_chip	Indicator identifying the record refers to a Medicaid (Title XIX) or CHIP (Title XXI) payment.	Yes	Yes	numeric	1 - Medicaid (Title XIX) 2 - CHIP (Title XXI)
State Funding Code	state_funding_code	Code that indicates whether the claim is matched with Title XIX, Title XXI, state-only or local funds, or other funding source.	Yes	Yes	varchar	State-specific values
Record Type	record_type	Code indicating whether the record is a claim header or a detail/line.	Yes	Yes	varchar	'H' – Header Record 'L' – Line Record
Fixed Payment Indicator	fixed_payment_ind	Code indicating whether the claim or payment conforms to the PERM FFS	Yes		numeric	0 - FFS Claim 1 – Capitated or Fixed Payment

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		fixed/capitated payment definition.				
Adjustment Indicator	adjustment_ind	Code indicating whether the claim/line is an adjustment and the type of adjustment (e.g. original claim, void, credit, debit, etc.	Yes	Yes	varchar	State-specific values
Date Paid Header	date_of_payment_header	The date a claim or payment was originally adjudicated or paid; not the check date (unless there is no adjudication date)	Yes	Yes	varchar (mm/dd/yyyy)	
Medicare Crossover Indicator Header	mcare_xover_ind_header	Header-level indicator that a claim is a crossover claim from Medicare to Medicaid	Yes		varchar	"Y"= Crossover "N"= Not a Crossover Ensure all values are coded as "Y" or "N" and the field is populated for all records
Category of Service	service_category	Classification for broad types of state/federal covered services	Yes		varchar	Can be MSIS category of service or state-defined service type

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Source Location	source_location	The system of origin/location in which the claim was originally adjudicated	Yes	Yes	varchar	State-specific values
Payment Status Header	payment_status_header	Paid or denied indicator for a claim as it was originally adjudicated; should not reflect an adjusted payment status	Yes	Yes	varchar	State-specific values
Total Computable Amount Paid Header	amt_paid_header	Total computable amount for the claim (at the header). Total Computable Amount = Federal Share + State Share + Any local share Amount paid should be net of all recipient and third party cost sharing (co-payments, TPL, coinsurance, etc.) recipient	Yes	Yes	numeric (with decimal)	Ensure the field is not truncated or rounded, and does not contain extra data
Third Party Liability (TPL) Amount Header	tpl_amt_header	Third Party Liability (TPL) refers to the legal obligation of	Yes		numeric (with decimal)	Ensure the field is not truncated or rounded, and

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. This is the total amount denoted at the claim header level paid by the third party.				does not contain extra data
Date-of-service From Header	dos_from_header	Beginning date of service on the claim For managed care payments, this field is used to report the beginning date of the coverage period	Yes	Yes	varchar (mm/dd/yyyy)	Ensure beginning date of service is a valid date, is populated for all records, and is prior to the ending date of service for the claim.
Date-of-service To Header	dos_to_header	End date of service on the claim For managed care payments, this field is used to report the end date of the coverage period	Yes	Yes	varchar (mm/dd/yyyy)	Ensure end date of service is a valid date, is populated for all records and is after the beginning date of service for the claim.

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Recipient ID	recipient_id	Recipient ID number Can be Medicaid ID or system-specific ID	Yes	Yes	varchar	This number must match a Recipient ID in the Recipient File
Billing provider number	billing_prov_id	Billing provider ID number Can be NPI or legacy provider ID	Yes	Yes	varchar	This number must match a Provider NPI number or Provider number in the Provider File
Referring provider number	ref_prov_id	Referring/Prescribing provider number Can be NPI or legacy provider ID	Yes		varchar	Must be submitted for records billed at the claim line and header level, when available
ICD procedure code 1	icd_proc_code_1	ICD-9/10 surgical procedure code 1	Yes		varchar	
ICD procedure code 2	icd_proc_code_2	ICD-9/10 surgical procedure code 2	Yes		varchar	
ICD procedure code 3	icd_proc_code_3	ICD-9/10 surgical procedure code 3	Yes		varchar	
ICD procedure code 4	icd_proc_code_4	ICD-9/10 surgical procedure code 4	Yes		varchar	
ICD procedure code 5	icd_proc_code_5	ICD-9/10 surgical procedure code 5	Yes		varchar	
ICD procedure code 6	icd_proc_code_6	ICD-9/10 surgical procedure code 6	Yes		varchar	

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Diagnosis 1	diag_code_1	Diagnosis code 1 (primary)	Yes		varchar	
Diagnosis 2	diag_code_2	Diagnosis code 2	Yes		varchar	
Diagnosis 3	diag_code_3	Diagnosis code 3	Yes		varchar	
Diagnosis 4	diag_code_4	Diagnosis code 4	Yes		varchar	
Diagnosis 5	diag_code_5	Diagnosis code 5	Yes		varchar	
Diagnosis 6	diag_code_6	Diagnosis code 6	Yes		varchar	
Diagnosis 7	diag_code_7	Diagnosis code 7	Yes		varchar	
Diagnosis 8	diag_code_8	Diagnosis code 8	Yes		varchar	
Diagnosis 9	diag_code_9	Diagnosis code 9	Yes		varchar	
DRG	drg_code	Diagnosis Related Group (DRG) code, if applicable	Yes		varchar	
Line item number	line_item_num	Number denoting individual claim detail/line item	Yes		numeric (no decimals)	
Line item number former	line_item_num_former	For adjustment claims, number to identify the transaction line number for the claim that the current claim is	Yes		numeric (no decimals)	

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		adjusting				
Date Paid Line	date_of_payment_line	The date a payment line was originally adjudicated or paid	Yes		varchar (mm/dd/yyyy)	For most claims and payments, this value is the same as Date Paid Header
Medicare Crossover Indicator Line	mcare_xover_ind_line	Line-level indicator that a claim is a crossover claim from Medicare to Medicaid	Yes		varchar	“Y”= Crossover “N”= Not a Crossover Ensure all values are coded as “Y” or “N” and the field is populated for all records
Payment Status Line	payment_status_line	Paid or denied indicator for a claim line as it was originally adjudicated; should not reflect an adjusted payment Status	Yes		varchar	State-specific values
Total Computable Amount Paid Line	amt_paid_line	Total computable amount paid at the claim line. Total Computable Amount= Federal Share + State Share + Any local share	Yes		numeric (with decimals)	Ensure the field is not truncated or rounded, and does not contain extra data

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		Amount paid should be net of all recipient and third party cost sharing (co-payments, TPL, coinsurance, etc.) recipient				
Units paid	units_of_svc_paid	Number of units (services) paid	Yes		numeric	<p>In cases where there are fractional units paid, ensure that they are valid and reflect the accurate number of units paid for the corresponding claim</p> <p>All paid drug records must have valid units paid greater than 0</p> <p>If the number of units paid for pharmacy claims are not available, please include quantity dispensed or other relevant information</p>

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Third Party Liability (TPL) Amount Line	tpl_amt_line	Third Party Liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. This is the total amount denoted at the claim detail level paid by the third party.	Yes		numeric (with decimals)	Ensure the field is not truncated, rounded and does not contain extra data
Procedure code line	proc_code_line	Procedure code on the line (HCPCS, CPT, or proprietary code) as it was adjudicated If proprietary codes are used, State must indicate as such and provide necessary decode information.	Yes		varchar	
Procedure modifier 1	proc_mod_1	Procedure Code Modifier- 1 on the lines as it was adjudicated	Yes		varchar	

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Procedure modifier 2	proc_mod_2	Procedure Code Modifier – 2 on the line as it was adjudicated	Yes		varchar	
Procedure modifier 3	proc_mod_3	Procedure Code Modifier – 3 on the line as it was adjudicated	Yes		varchar	
Procedure modifier 4	proc_mod_4	Procedure Code Modifier – 4 on the line as it was adjudicated	Yes		varchar	
Revenue code	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	Yes		varchar	
Performing provider number	perf_prov_id	Performing (servicing/rendering /attending) provider ID number Can be NPI or legacy provider ID	Yes		varchar	This number must match a Provider NPI number or Provider Number in the Provider File

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Date-of-service From Line	dos_from_line	Beginning date of service on the line Should be included for each line of a claim	Yes		varchar (mm/dd/yyyy)	Ensure beginning date of service is a valid date, is populated for all line level claims, and is prior to the ending date of service for the line claims
Date-of-service To Line	dos_to_line	End date of service on the line Should be included for each line of a claim	Yes		Varchar (mm/dd/yyyy)	Ensure end date of service is a valid date, is populated for all line level claims and is after the beginning date of service for line claims
Place of service	place_of_svc	Place of service	Yes		varchar	State-specific values
Type of service	type_of_svc	Type of service	Yes		varchar	State-specific values
National Drug Code (NDC)	ndc_code	Made up of labeler(mfr) + product + pkg size configurations	Yes		varchar	Must be 11 digits including leading and trailing zeroes Ensure this field is populated for ALL pharmacy

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
						claims
Drug order date	drug_order_dt	Date drug was prescribed for the pharmacy claim	Yes		varchar (mm/dd/yyyy)	Ensure this field is populated for ALL pharmacy claims
Prescription number	rx_num	Prescription number for the pharmacy claim	Yes		varchar	Ensure this field is populated for ALL pharmacy claims
Prior authorization number	prior_auth_num	Prior authorization number	Yes		varchar	State-specific values
Managed care program indicator	program_indicator	Indicator of the program (TANF, PACE, LTC, Behavioral health)		Yes	varchar	State-specific values
Payment type	payment_type	Type of managed care payment (e.g., monthly capitation, delivery kick payment or other recipient-specific supplemental payment, individual reinsurance payment)		Yes	varchar	State-specific values
Recipient rate indicator	recipient_rate_indicator	Rate cell or rate group used to determine the payment for the		Yes	varchar	State-specific values

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		recipient to the managed care plan				
Recipient aid category	recipient_aid_category	Eligibility type		Yes	varchar	State-specific values
ICD Version	ICD_version	<p>If the state will be submitting details with a mix of ICD-9 and ICD-10 codes, populate field with a value of either “9” or “10” to indicate the version number.</p> <p>If all diagnosis codes are the same version, states are not required to populate this field but should notify Lewin which ICD version is being used.</p>			numeric	<p>“9” ICD-9</p> <p>“10” ICD-10</p>
User field 1		<p>User- specific field that may contain unique state data that is important for the program but is not in the standard format</p> <p>State may exclude this field, if desired</p>				

Appendix A: Claim Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
User field 2		Same as above				
User field 3		Same as above				
User field 4		Same as above				
User field 5		Same as above				
User field 6		Same as above				
User field 7		Same as above				
User field 8		Same as above				
User field 9		Same as above				
User field 10		Same as above				

6.4 Appendix B—Recipient File Fields

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
Recipient ID	recipient_id	Recipient ID number Can be Medicaid ID or system-specific ID	varchar	
Recipient name	recipient_name	Recipient Name States may submit recipient name according to state preference (e.g., can submit multiple fields for first, middle, and last name or a single field containing recipient full name)	varchar	
Recipient date of birth	recipient_dob	Recipient date of birth	varchar (mm/dd/yyyy)	
Recipient gender	recipient_gender	Recipient gender code	varchar	Ensure all values are coded as “M” or “F” and the field is populated for all records
Recipient county	recipient_county	Recipient county	varchar	State-specific values
Service area indicator	service_area_ind	Indicator for the geographic service area if the service area is not the county	varchar	State-specific values

6.5 Appendix C—Provider File Fields

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
Medical Record Contact Name	mr_contact_name	Medical record contact name	varchar	<p>Ensure this field is populated when available</p> <p>Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers</p>
Medical Record Contact Add 1	mr_contact_addr_1	Medical record contact address first line	varchar	<p>Ensure this field is populated when available</p> <p>Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers</p>
Medical Record Contact Addr 2	mr_contact_addr_2	Medical record contact address second line	varchar	<p>Ensure this field is populated when available</p> <p>Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers</p>

Appendix C: Provider Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
Medical Record Contact City	mr_contact_city	Medical record contact city	varchar	<p>Ensure this field is populated when available</p> <p>Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers</p>
Medical Record Contact State	mr_contact_state	Medical record contact state: 2-character postal abbreviation.	varchar	<p>Ensure this field is populated when available</p> <p>Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers</p> <p>Use the abbreviated 2-letter code for each state (e.g. WA for Washington state)</p>
Medical Record Contact Zip	mr_contact_zip_code	<p>Medical record contact zip code.</p> <p>Should contain either 5 or 9 digits (ZIP+4 digit code)</p>	varchar	<p>Ensure this field is populated when available</p> <p>Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers</p> <p>If possible do not</p>

Appendix C: Provider Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
				include hyphens when using a ZIP+4 digit code
Medical Record Contact Phone	mr_contact_phone	Medical record contact phone number. All phone numbers should be 10 digits, including the area code	varchar	Ensure this field is populated when available Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers
Provider number	prov_id	Provider ID Can be NPI or legacy provider ID	varchar	State-specific values
Provider name	prov_name	Provider name	varchar	
Provider type	prov_type	Provider type	varchar	State-specific values
Provider specialty	prov_spec	Provider specialty code	varchar	State-specific values
Provider address 1	prov_addr_1	Provider address first line	varchar	
Provider address 2	prov_addr_2	Provider address second line	varchar	
Provider city	prov_city	Provider city	varchar	
Provider state	prov_state	Provider state	varchar	Use the abbreviated 2-letter code for each state (e.g. WA for Washington state)

Appendix C: Provider Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
Provider zip	prov_zip_code	Provider zip code Should contain either 5 or 9 digits (ZIP+4 digit code)	varchar	If possible do not include hyphens when using a ZIP+4 digit code
Provider phone	prov_phone	Provider phone number(s) All phone numbers should be 10 digits, including the area code	varchar	If possible, do not use hyphens or parentheses
Provider fax	prov_fax	Provider fax number, when available All fax numbers should be 10 digits, including the area code	varchar	If possible, do not use hyphens or parentheses
Provider NPI	prov_npi	Provider NPI, if available	varchar	

6.6 Appendix D—PERM+ Transmission Cover Sheets

These forms will also be provided to the state in MS Excel (".xlsx" file format).

Transmission Cover Sheet									
PERM Plus - Claims File									
State:									
Date:									
Quarter:									
Data Descriptions: Complete the information below for each submitted file. If submitting data documentation, please include a row describing the documentation. Add more rows as necessary.									
Data Description (e.g., Q1 Claims Header File; data documentation)						File Format (e.g., text, Excel, SAS)	File Media (e.g., CD, DVD, FTP)	Password Protected? (Y/N) (if yes, send password separately)	
Data Filename									
(Add rows if necessary)									
Control Totals: If submitting more than two data files, copy and paste additional control totals tables.									
NOTE: List the total # of records and total dollars by STATE CLAIM TYPE, not universe totals. Add more rows as necessary to reflect each state claim type.									
Data Filename:									
State Claim Type	Month October		State Claim Type	Month November		State Claim Type	Month December		
	Total # of Records	Total Dollars		Total # of Records	Total Dollars		Total # of Records	Total Dollars	
(Add rows if necessary)									
Data Filename:									
State Claim Type	Month October		State Claim Type	Month November		State Claim Type	Month December		
	Total # of Records	Total Dollars		Total # of Records	Total Dollars		Total # of Records	Total Dollars	
(Add rows if necessary)									

Appendix D: PERM+ Transmission Cover Sheets

Transmission Cover Sheet					
PERM Plus - Beneficiary File					
State:					
Date:					
Quarter:					
Data Descriptions and Control Totals: Complete the information below for each submitted file. If submitting data documentation, please include a row describing the documentation. Add more rows as necessary. For files containing data, please include the total # of records.					
Data Description (e.g., Q1 Recipient File; data documentation)	Data Filename	File Format (e.g., text, Excel, SAS)	File Media (e.g., CD, DVD, FTP)	Total # of Records	Password Protected? (Y/N) (if yes, send password separately)
(Add rows if necessary)					

Transmission Cover Sheet					
PERM Plus - Provider File					
State:					
Date:					
Quarter:					
Data Descriptions and Control Totals: Complete the information below for each submitted file. If submitting data documentation, please include a row describing the documentation. Add more rows as necessary. For files containing data, please include the total # of records.					
Data Description (e.g., Q1 Provider File; data documentation)	Data Filename	File Format (e.g., text, Excel, SAS)	File Media (e.g., CD, DVD, FTP)	Total # of Records	Password Protected? (Y/N) (if yes, send password separately)
(Add rows if necessary)					