

# **2013 PERM Plus Data Submission Instructions**

**July 30, 2012**

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## **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. 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.

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 beneficiary-specific payments and many aggregate payments (together referred to as the PERM "universe"), as well as beneficiary and provider information.

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 and a Transmission Cover Sheet for quality control verification.

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.

### **PERM Plus**

PERM Plus is an innovative way for states, CMS, and the CMS PERM contractors to approach data submission for the claims and payments portion of PERM. Select fiscal year (FY) 2013 PERM states will collect data for Medicaid and/or CHIP data using these PERM Plus instructions. States not engaging in PERM Plus will continue to submit claims and payments according to the "routine" PERM instructions, similar to those used in past PERM cycles.<sup>1</sup>

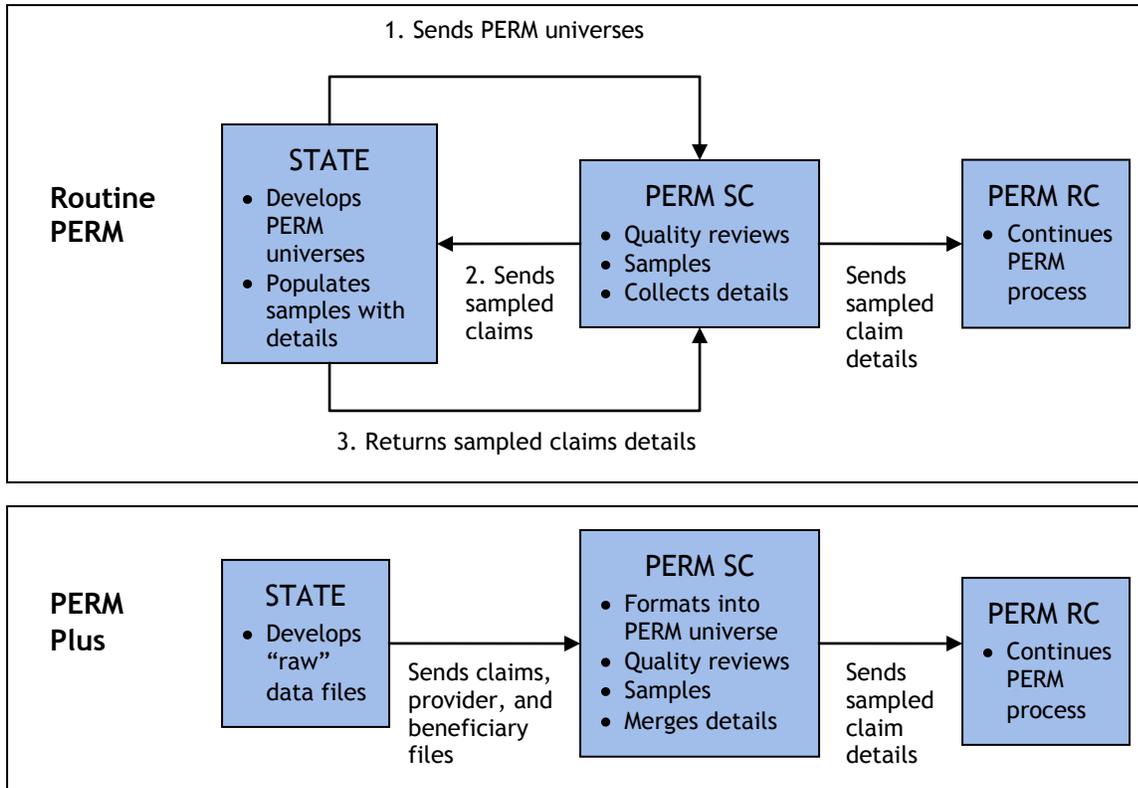
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<sup>1</sup> States may select to submit both Medicaid and CHIP under PERM Plus or to submit PERM data using a combination of PERM Plus and routine PERM.

## PERM Plus Objectives

Through the PERM Plus initiative, CMS seeks to simplify the PERM data submission process by having states submit claims, beneficiary data, and provider data 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 Plus.

**Exhibit 1: Data Flow in Routine PERM and PERM Plus**



PERM Plus also requires less upfront analysis and data modifications by the state because the PERM Statistical Contractor (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 method and removing records that do not qualify for sampling) and dividing the PERM Plus data submissions into fee-for-service and managed care datasets for sampling.

## Initial Preparations for PERM Plus

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 Plus 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 Plus data submissions, and that the SC has correctly applied the state's claims payment rules to

“build” the PERM universes. 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 (HIPPP) 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 15, 2013) 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 beneficiary files for PERM Plus 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 2: FY 2013 PERM Plus Data Submission Timeline

Date	State Activities	SC/CMS Activities
August 2012	<ul style="list-style-type: none"> <li>✓ Determine if the state will submit via PERM Plus or routine PERM</li> <li>✓ Select PERM team</li> </ul>	<ul style="list-style-type: none"> <li>✓ Meet with select states to discuss the PERM Plus submission option</li> <li>✓ Answer questions about PERM Plus</li> </ul>
September 2012	<ul style="list-style-type: none"> <li>✓ Schedule state orientation meeting</li> </ul>	<ul style="list-style-type: none"> <li>✓ Organize state orientation meeting</li> </ul>
October - December 2012	<ul style="list-style-type: none"> <li>✓ Participate in an orientation meeting</li> <li>✓ Review Data Submission Instructions</li> <li>✓ Ask questions and provide feedback</li> </ul>	<ul style="list-style-type: none"> <li>✓ Participate in an orientation meeting</li> <li>✓ Answer questions from and provide feedback to PERM Plus states</li> </ul>
December 2012	<ul style="list-style-type: none"> <li>✓ Code programs to provide PERM Plus datasets</li> <li>✓ Ask questions and provide feedback</li> </ul>	<ul style="list-style-type: none"> <li>✓ Answer questions from and provide feedback to PERM Plus states</li> </ul>
January 15, 2013	<ul style="list-style-type: none"> <li>✓ Submit Q1 PERM Plus data to the SC</li> </ul>	<ul style="list-style-type: none"> <li>✓ Receive Q1 PERM Plus data from states</li> </ul>
January 15 - February 2013	<ul style="list-style-type: none"> <li>✓ Work with SC to resolve issues identified during the data validation and QC Process</li> <li>✓ Review SC plans to build PERM universes</li> </ul>	<ul style="list-style-type: none"> <li>✓ Begin SC data validation and QC Process</li> <li>✓ Receive state approval for plans to build PERM universes</li> <li>✓ Build PERM universes</li> </ul>
March-April 2013	<ul style="list-style-type: none"> <li>✓ Work with SC to resolve issues identified QC of PERM universes</li> </ul>	<ul style="list-style-type: none"> <li>✓ Perform QC review of PERM universes</li> <li>✓ Select Q1 samples</li> </ul>
Within 30 days after sampling	<ul style="list-style-type: none"> <li>✓ Work with SC to resolve issues with PERM details data</li> </ul>	<ul style="list-style-type: none"> <li>✓ Build and format Q1 PERM details submissions</li> <li>✓ Transmit formatted details to the RC</li> </ul>
April 15, 2013	<ul style="list-style-type: none"> <li>✓ Submit Q2 PERM Plus data to the SC</li> </ul>	<ul style="list-style-type: none"> <li>✓ Receive Q2 PERM Plus data from states</li> </ul>
April 16 - June 2013	<ul style="list-style-type: none"> <li>✓ Work with SC to resolve issues identified QC of PERM universes</li> </ul>	<ul style="list-style-type: none"> <li>✓ Build PERM universes</li> <li>✓ Perform QC review of PERM universes</li> <li>✓ Select Q2 samples</li> </ul>
Within 30 days after sampling	<ul style="list-style-type: none"> <li>✓ Work with SC to resolve issues with PERM details data</li> </ul>	<ul style="list-style-type: none"> <li>✓ Build and format Q2 PERM details submissions</li> <li>✓ Transmit formatted details to the RC</li> </ul>
July 15, 2013	<ul style="list-style-type: none"> <li>✓ Submit Q3 PERM Plus data to the SC</li> </ul>	<ul style="list-style-type: none"> <li>✓ Receive Q3 PERM Plus data from states</li> </ul>
July 16 - September 2013	<ul style="list-style-type: none"> <li>✓ Work with SC to resolve issues identified QC of PERM universes</li> </ul>	<ul style="list-style-type: none"> <li>✓ Build PERM universes</li> <li>✓ Perform QC review of PERM universes</li> <li>✓ Select Q3 samples</li> </ul>
Within 30 days after sampling	<ul style="list-style-type: none"> <li>✓ Work with SC to resolve issues with PERM details data</li> </ul>	<ul style="list-style-type: none"> <li>✓ Build and format Q3 PERM details submissions</li> <li>✓ Transmit formatted details to the RC</li> </ul>

*FY 2013 PERM Plus Data Submission Instructions*

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Date	State Activities	SC/CMS Activities
<b>October 15, 2013</b>	✓ Submit Q4 PERM Plus data to the SC	✓ Receive Q4 PERM Plus data from states
<b>October 16 - December, 2013</b>	✓ Work with SC to resolve issues identified QC of PERM universes	✓ Build PERM universes ✓ Perform QC review of PERM universes ✓ Select Q4 samples
<b>Within 30 days after sampling</b>	✓ Work with SC to resolve issues with PERM details data	✓ Build and format Q4 PERM details submissions ✓ Transmit formatted details to the RC

## Section 2: PERM Plus Data File Specifications

This section addresses the content of the PERM Plus data submissions, including the structure of the submission, details of the payments to include and not include in the PERM Plus data submissions (which claims are “in” and which are “out”), and descriptions of the required fields and field requirements.

### File Structure

For PERM Plus, the states submit to the SC data files containing all fields needed for claims sampling and medical record requests (see Exhibit 3). States submit PERM Plus data in three files: claim information, beneficiary information, and provider information.

#### Exhibit 3: Claims, Provider, and Beneficiary Data are Required for PERM Plus Submissions



### Claim Header and Claim Detail Files

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

PERM Plus offers states flexibility in file submission structure. PERM Plus 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). Each state will work with the SC to determine the most appropriate file structure for the state’s data and claims payment system structure.

#### Caution!

Remember that not everything processed in MMIS is matched with Medicaid or CHIP funds! Do not include state-only funded services or services provided with financial funds from any federal programs other than Title XIX or Title XXI in the PERM Plus data.

### Beneficiary and Provider Files

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

beneficiary file, states should include beneficiary records for all beneficiaries 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 beneficiary file.

## **Universe Parameters**

The PERM Plus data submission is defined 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 Plus 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 universes.

### ***Date***

PERM universes include claims and payments originally processed during the federal fiscal year under review. For example, for the FY 2013 PERM cycle, the state's PERM universe includes claims and payments with original dates of payment between October 1, 2012 and September 30, 2013.

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 fifteen days after the end of each quarter. See Exhibit 4 for the data submission due dates for FY 2013 and the paid claim dates to be included in each quarterly submission.

**Exhibit 4: Federal Fiscal Quarters and PERM Data Submission Dates, FY 2013**

<b>FY 2013 Quarter</b>	<b>Claim Date Paid</b>	<b>Data Submission Due</b>
Quarter 1	October 1 - December 31, 2012	January 15, 2013
Quarter 2	January 1 - March 31, 2013	April 15, 2013
Quarter 3	April 1 - June 30, 2013	July 15, 2013
Quarter 4	July 1 - September 30, 2013	October 15, 2013

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 Plus 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 Plus data, again, based on the original paid date.

States may submit the adjudication date instead of the original paid date in the PERM Plus data submission as long as the state maintains a consistent date approach throughout all four quarterly data 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 dataset submitted for those claims are consistent over the course of the year. For example, a state could submit all MMIS claims using paid date but submit all off-MMIS HIPP payments using adjudication 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 Plus data submission based on paid date as well.

- *Prospective example:* A state makes a capitation payment on December 25, 2012 for services in January 2013. The state includes the payment with the PERM Plus quarter 1 data submission.
- *Retrospective example:* A state makes a capitation payment on October 5, 2012 for services in September 2012. The state should include the payment with the PERM Plus quarter 1 data submission.

### ***Program***

Generally, states include in their PERM Plus data submissions all beneficiary-level claims and payments and certain aggregate payments for services provided to individual beneficiaries for which the state receives federal financial participation (FFP) through Title XIX or Title XXI (limited exclusions are discussed in a later 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 their PERM Plus data submissions. As CMS must report separate error rates for the Medicaid and CHIP programs, the SC will need to assign claims in the PERM Plus data submission to either Title XIX or Title XXI. States will need to populate a field called “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. 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 indicate through the Medicaid/CHIP Indicator field that the claims and payments for both these Title XXI programs are assigned to CHIP.
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 Plus 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. For PERM Plus, consider these Medicaid claims. As described in Appendix A, states should show that a claim or payment is Medicaid (Title XIX) using a Medicaid/CHIP Indicator of “1”.

Also include in the PERM Plus claims file all Medicaid expansion and/or stand-alone CHIP payments in the PERM Plus 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. For PERM Plus, consider these payments as CHIP claims. As described in Appendix A, states should show that a claim or payment is CHIP (Title XXI) using a Medicaid/CHIP Indicator of “2”.

Appendix A also includes a field called “State Funding Code”. States may populate this field with any state-specific value that shows that the state requested federal Title XIX or Title XXI match for a 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 Plus claims file. 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 Plus claims file.

### ***Adjudicated claims***

States should only include fully adjudicated claims and payments in their PERM Plus 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 Plus 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. The SC will need guidance from states to separate fee-for-service (which includes fixed payments) and managed care payments. For example, a state may identify these payment types using the state's claim type ("Claim Type" field in Appendix A), or a state may advise the SC to rely on a combination of fields.

### ***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*

Managed care payments are fully and partially capitated payments. These include:

- 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 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 (PCCM) fees paid to participating providers
- 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. Fixed payments must be identified in the claims file by using the “Fixed Payment Indicator” field.

### *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 Plus data submissions. Aggregate payments are included in the PERM regardless if 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 Plus submission when the payment is not beneficiary-specific:<sup>2</sup>

- 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 Part A and Part B premium payments (“buy-in”) in the PERM Plus 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 Plus 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

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<sup>2</sup> States may include these in the PERM Plus submissions if the payments are readily identifiable and the state instructs the SC to remove the payments prior to sampling.

include these in the PERM Plus 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 not required to remove claim or payment adjustments from the PERM Plus data submissions. Adjustments have to be identified in the data via the “Adjustment Indicator” field.

### **Data Sources**

States generally draw a majority of PERM Plus 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 Plus data submissions. PERM Plus 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

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.

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

### **Sampling Units in the PERM Plus 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 Plus, 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 details records for all claims for PERM Plus. States also need to provide guidance to help the SC identify header and line records in the claims submission. Submitting all of the header and detail information for a claim is a key difference between the PERM Plus 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 data and the payment guidance from the state to develop the PERM sampling units.

### Section 3: Quality Review

States are responsible for performing a quality review of their PERM Plus data submissions each quarter before submitting files to the SC. State 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 are 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	<ul style="list-style-type: none"> <li>○ 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</li> <li>○ Identify any missing fields</li> <li>○ Determine why the field is missing; if the state does not report a field, let the SC know when submitting the file</li> </ul>
2) Check that key fields are properly formatted and have valid values	<ul style="list-style-type: none"> <li>○ Check that key fields are not truncated or contain extra data. Review fields such as:                             <ul style="list-style-type: none"> <li>- ICN</li> <li>- Line Item Number</li> <li>- Billing Provider Number</li> <li>- Beneficiary ID</li> <li>- Total Computable Amount Paid Header</li> <li>- Total Computable Amount Paid Line</li> </ul> </li> </ul>
3) Check that the Date Paid Header and/or the Date Paid Line for all records is for the appropriate quarter for FY 2013	<ul style="list-style-type: none"> <li>○ Only include payments that were adjudicated in the appropriate quarter for FY 2013</li> </ul>
4) Confirm that the SC can identify claims as Medicaid (Title XIX) or CHIP (Title XXI)	<ul style="list-style-type: none"> <li>○ Confirm that data is present and documentation is available that would allow the SC to assign claims to Medicaid or CHIP PERM universes</li> </ul>
5) Confirm that the SC can identify claims as Fee-for-Service or Managed Care	<ul style="list-style-type: none"> <li>○ Confirm that data is present and documentation is available that would allow the SC to assign claims to fee-for-service or managed care universes</li> </ul>
6) Check that the following payment records can be identified by the SC: <ul style="list-style-type: none"> <li>- Adjustments and voids</li> <li>- State-only claims</li> <li>- Gross adjustments</li> <li>- Claims matched with federal funds other than Title XIX or Title XXI</li> </ul>	<ul style="list-style-type: none"> <li>○ Confirm that data is present and documentation is available that would allow the SC to identify and remove these records</li> </ul>

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

**Exhibit 6: Minimum Beneficiary File Quality Control Checks**

Quality Control Check	Suggested Tests
1) Make sure all required fields are reported in the beneficiary file	<ul style="list-style-type: none"> <li>○ Prepare a list of all fields in the state's beneficiary file and compare it to the list for the beneficiary file in Appendix B</li> <li>○ Identify any missing fields</li> <li>○ Determine why the field is missing; if the state does not report a field, let the SC know when submitting the file</li> </ul>
2) Check that the Beneficiary Number field is properly formatted	<ul style="list-style-type: none"> <li>○ Check that the Beneficiary ID field is not truncated or has additional data</li> <li>○ Replace the data in the Beneficiary ID field if formatting problems are found</li> </ul>

**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"> <li>○ 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</li> <li>○ Identify any missing fields</li> <li>○ Determine why the field is missing; if the state does not report a field, let the SC know when submitting the file</li> </ul>
2) Check that key fields are properly formatted	<ul style="list-style-type: none"> <li>○ 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</li> <li>○ Replace the data in the Provider Number or the Provider NPI field if formatting problems are found</li> </ul>

## **State PERM Plus Claims File Quality Guidance**

States should compare their PERM Plus data submissions to CMS-64 and CMS-21 Financial Reports, respectively, to ensure that the claims file is complete and accurate. Comparing the claims 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 claims file and that the state is capturing all necessary data sources in the claims file. 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, and inform the SC of any major discrepancies.

We recommend that states identify the portions of the CMS-64 and CMS-21 Financial Reports that are not appropriate to compare to the PERM claims file (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 should then compare the CMS-64 and CMS-21 Financial Report totals to their FFS and managed care data in the claims file. States should confirm that no programs that appear on the CMS Financial Reports have been omitted from the claims file. In addition, significant differences between PERM claims file and Financial Reports, as defined by the state, should be reported to the SC.

## Section 4: Data Transmission and Security

This section discusses the PERM Plus data submission media, PERM Plus 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. 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 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

## Appendices

### Fields for PERM Plus

Appendices A, B, and C list the fields for states to include with the PERM Plus data submissions. PERM Plus data submissions include provider, beneficiary, 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 Plus data submission – similar to the field requirements in the routine PERM detail submission.

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

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

### PERM Plus Transmission Cover Sheets

Appendix D shows copies of the Transmission Cover Sheets that states should use when submitting files for PERM Plus. There are separate cover sheets for the claims file, beneficiary 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 Plus.

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**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)	X	X	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</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 (TCN) of the claim that the current claim	X	X		

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		is adjusting				
Claim type	clm_type	State claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim	X	X	varchar	State-specific values
Medicaid/CHIP Indicator	medicaid_chip	Indicator identifying the payment as either a Medicaid (Title XIX) or CHIP (Title XXI) payment.	X	X	numeric	1 - Medicaid (Title XIX) 2 - CHIP (Title XXI)
State Funding Code	state_funding_code	Code that indicates if the claim was matched with Title XIX, Title XXI, local funds, or other funding source.	X	X	varchar	Use state-specific values
Record Type	record_type	The code used to denote if the record is a header or a line.	X	X	varchar	'H' - Header Record 'L' - Line Record
Fixed Payment	fixed_payment_ind	Indicator if the claim or payment conforms	X		numeric	0 - Not a FFS Fixed Payment

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Indicator		to the PERM FFS fixed payment definition.				1 - FFS Fixed Payment
Adjustment Indicator	adjustment_ind	Code indicating type of adjustment record claim represents (e.g. original claim, void, credit, debit, etc.	X	X	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)	X	X	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	X		varchar	<p>“Y”= Crossover “N”= Not a Crossover</p> <p>Ensure all values are coded as “Y” or “N” and the field is populated for all records</p>

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Category of Service	service_category	Classification for broad types of state/federal covered services	X		varchar	Can be MSIS category of service or state-defined service type
Source Location	source_location	The system of origin/location in which the claim was adjudicated	X	X	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	X	X	varchar	State-specific values
Total Computable Amount Paid Header	amt_paid_header	Total computable amount paid at the claim header.  Total Computable Amount = Federal Share + State Share  Amount paid should	X	X	numeric (with decimals)	Ensure the field is not truncated or rounded, and does not contain extra data

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		be net of any co-payments, third-party, or other beneficiary liability				
Third Party Liability (TPL) Amount Header	tpl_amt_header	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 header level paid by the third party.	X		numeric (with decimals)	Ensure the field is not truncated or rounded, and does not contain extra data
Date-of-service From Header (Fee-for-Service claims)	dos_from_header	Beginning date of service on the claim  For managed care claims, this field is used to report the	X	X	varchar (mm/dd/yyyy)	Ensure beginning date of service is populated for all records.

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		beginning date of the coverage period				
Date-of-service To Header (Fee-for-Service claims)	dos_to_header	Ending date of service on the claim  For managed care claims, this field is used to report the ending date of the coverage period	X	X	vchar (mm/dd/yyyy)	Ensure ending date of service is populated for all records.
Beneficiary ID	recipient_id	Beneficiary ID number	X	X	vchar	This number must match a Recipient ID in the Beneficiary File
Billing provider number	billing_prov_id	Billing provider ID number	X	X	vchar	This number must match a Provider NPI number or Provider number in the Provider File
ICD procedure code 1	icd_proc_code_1	ICD-9/10 surgical procedure code 1	X		vchar	
ICD procedure code 2	icd_proc_code_2	ICD-9/10 surgical procedure code 2	X		vchar	

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
ICD procedure code 3	icd_proc_code_3	ICD-9/10 surgical procedure code 3	X		varchar	
ICD procedure code 4	icd_proc_code_4	ICD-9/10 surgical procedure code 4	X		varchar	
ICD procedure code 5	icd_proc_code_5	ICD-9/10 surgical procedure code 5	X		varchar	
ICD procedure code 6	icd_proc_code_6	ICD-9/10 surgical procedure code 6	X		varchar	
Diagnosis 1	diag_code_1	Diagnosis code 1 (primary)	X		varchar	
Diagnosis 2	diag_code_2	Diagnosis code 2	X		varchar	
Diagnosis 3	diag_code_3	Diagnosis code 3	X		varchar	
Diagnosis 4	diag_code_4	Diagnosis code 4	X		varchar	
Diagnosis 5	diag_code_5	Diagnosis code 5	X		varchar	
Diagnosis 6	diag_code_6	Diagnosis code 6	X		varchar	
Diagnosis 7	diag_code_7	Diagnosis code 7	X		varchar	
Diagnosis 8	diag_code_8	Diagnosis code 8	X		varchar	

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Diagnosis 9	diag_code_9	Diagnosis code 9	X		varchar	
DRG	drg_code	Diagnosis Related Group (DRG) code, if applicable	X		varchar	
Line item number	line_item_num	Line number of the individual line item number	X		numeric (no decimals)	
Line item number former	line_item_num_former	For adjustment claims, a unique number to identify the transaction line number for the claim that the current claim is adjusting	X		numeric (no decimals)	
Date Paid Line	date_of_payment_line	The date a payment line was originally adjudicated or paid	X		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	X		varchar	“Y” = Crossover “N” = Not a Crossover  Ensure all values are coded as “Y” or

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
						"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	X		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  Amount paid should be net of any co-payments, third-party, or other beneficiary liability	X		numeric (with decimals)	Ensure the field is not truncated or rounded, and does not contain extra data

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Units paid	units_of_svc_paid	Number of units (services) paid	X		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>
Third Party Liability (TPL) Amount Line	tpl_amt_line	Third Party Liability (TPL) refers to the legal obligation of third parties, i.e.,	X		numeric (with decimals)	Ensure the field is not truncated, rounded and does not contain extra

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		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.				data
Procedure code line	proc_code_line	Procedure code on the line (HCPCS code or CPT) as it was adjudicated	X		varchar	
Procedure modifier 1	proc_mod_1	Procedure Code Modifier- 1 on the lines as it was adjudicated	X		varchar	
Procedure modifier 2	proc_mod_2	Procedure Code Modifier - 2 on the line as it was adjudicated	X		varchar	
Procedure modifier 3	proc_mod_3	Procedure Code Modifier - 3 on the	X		varchar	

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		line as it was adjudicated				
Procedure modifier 4	proc_mod_4	Procedure Code Modifier - 4 on the line as it was adjudicated	X		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	X		varchar	
Performing provider number	perf_prov_id	Performing (servicing) provider ID number	X		varchar	This number must match a Provider NPI number or Provider Number in the Provider File
Date-of-service From Line	dos_from_line	Beginning date of service on the line	X		varchar (mm/dd/yyyy)	Ensure beginning date of service is populated for all

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

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

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Drug order date	drug_order_dt	Date drug was prescribed for a pharmacy claim	X		varchar (mm/dd/yyyy)	Ensure this field is populated for all pharmacy claims
Prescription number	rx_num	Prescription number for the pharmacy claim line	X		varchar	Ensure this field is populated for all pharmacy claims
Prior authorization number	prior_auth_num	Prior authorization number	X		varchar	
Federal claim category	federal_claim_category	MSIS Code, CMS 64 line, or other state mapping into a federal claim category	X		varchar	Optional field
Managed care program indicator	program_indicator	Indicator of the program (TANF, PACE, LTC, Behavioral health)		X	varchar	State-specific values
Payment type	payment_type	E.g., monthly capitation, delivery kick payment or other beneficiary-specific supplemental payment, individual		X	varchar	State-specific values

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
		reinsurance payment				
Beneficiary rate indicator	recipient_rate_indicator	Rate cell or rate group used to determine the payment for the recipient to the managed care plan		X	varchar	State-specific values
Beneficiary aid category	recipient_aid_category	Eligibility type		X	varchar	State-specific values
User field 1		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				
User field 2		Same as above				
User field 3		Same as above				

**Appendix A**  
**Claim Fields for PERM Plus Data Submissions**

**Appendix A - Claims File Fields**

<b>Field Designation</b>	<b>Standard Field Name</b>	<b>Field Description</b>	<b>Required for FFS</b>	<b>Required for MC</b>	<b>Standard Field Format</b>	<b>Quality Review</b>
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				

**Appendix B**  
**Beneficiary Fields for PERM Plus Data Submissions**

**Appendix B - Beneficiary File Fields**

<b>Field Designation</b>	<b>Standard Field Name</b>	<b>Field Description</b>	<b>Standard Field Format</b>	<b>Quality Review</b>
Beneficiary ID	recipient_id	Beneficiary ID number	varchar	
Beneficiary name	recipient_name	Beneficiary Name States may submit beneficiary name according to state preference (e.g., can submit multiple variables for first, middle, and last name or a single variable containing beneficiary full name)	varchar	
Beneficiary date of birth	recipient_dob	Beneficiary date of birth	varchar (mm/dd/yyyy)	
Beneficiary gender	recipient_gender	Beneficiary gender code	varchar	Ensure all values are coded as "M" or "F" and the field is populated for all records
Beneficiary county	recipient_county	Beneficiary county	varchar	State-specific values

**Appendix B**  
**Beneficiary Fields for PERM Plus Data Submissions**

**Appendix B - Beneficiary File Fields**

<b>Field Designation</b>	<b>Standard Field Name</b>	<b>Field Description</b>	<b>Standard Field Format</b>	<b>Quality Review</b>
Service area indicator	service_area_ind	Indicator for the geographic service area if the service area is not the county	varchar	State-specific values

**Appendix C**  
**Provider Fields for PERM Plus Data Submissions**

**Appendix C - Provider File Fields**

<b>Field Designation</b>	<b>Standard Field Name</b>	<b>Field Description</b>	<b>Standard Field Format</b>	<b>Quality Review</b>
Provider number	prov_id	Provider ID number	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)
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

**Appendix C**  
**Provider Fields for PERM Plus Data Submissions**

**Appendix C - Provider File Fields**

<b>Field Designation</b>	<b>Standard Field Name</b>	<b>Field Description</b>	<b>Standard Field Format</b>	<b>Quality Review</b>
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	

**Appendix D**  
**PERM Plus Transmission Cover Sheets**

**Appendix D - PERM Plus Transmission Cover Sheets**

Transmission Cover Sheet								
PERM Plus - Claims File								
<b>State:</b>								
<b>Date:</b>								
<b>Quarter:</b>								
<b>Data Descriptions:</b> 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)	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)								
<b>Control Totals:</b> If submitting more than two data files, copy and paste additional control totals tables.								
<b>NOTE:</b> 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.								
<b>Data Filename:</b>								
Month October			Month November			Month December		
State Claim Type	Total # of Records	Total Dollars	State Claim Type	Total # of Records	Total Dollars	State Claim Type	Total # of Records	Total Dollars
(Add rows if necessary)								
<b>Data Filename:</b>								
Month October			Month November			Month December		
State Claim Type	Total # of Records	Total Dollars	State Claim Type	Total # of Records	Total Dollars	State Claim Type	Total # of Records	Total Dollars
(Add rows if necessary)								

## Appendix D PERM Plus Transmission Cover Sheets

Transmission Cover Sheet							
PERM Plus - Beneficiary File							
<b>State:</b>							
<b>Date:</b>							
<b>Quarter:</b>							
<b>Data Descriptions and Control Totals:</b> 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)		
<small>(Add rows if necessary)</small>							

Transmission Cover Sheet							
PERM Plus - Provider File							
<b>State:</b>							
<b>Date:</b>							
<b>Quarter:</b>							
<b>Data Descriptions and Control Totals:</b> 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.							
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