Payment Error Rate Measurement (PERM)
Office of Financial Management
Provider Compliance Group
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Policy for Handling Lost or Destroyed Documentation

A PERM measurement involves the review of documentation in support of a paid Fee for Service (FFS) claim in Medicaid and SCHIP. Providers are contacted and requested to submit documentation for review of their claims. A provider may be unable to provide documentation due to its loss or destruction from a natural disaster such as flood, hurricane, earthquake or tornado, and cases of fire. In the event of a Federal Emergency Management Agency (FEMA) declared disaster, the Statistical Contractor (SC) will drop the claim from the sample, and replace the claim with another randomly sampled claim if time allows. Determinations in the event of a fire will be made on a case by case basis.

Provider Attestation

The PERM Database and Documentation Contractor (DDC) sends requests for medical records/documentation to a provider to complete a medical review. If a provider is not able to supply the documentation due to loss or destruction from a disaster, the provider should submit an attestation statement (see Exhibit 1) by fax or mail to the DDC within 15 days of the date of the initial written request for documentation from the DDC.

Re-Sampling or Excluding Claims

In the event a provider's documentation has been lost or destroyed in a FEMA declared disaster, the sampled claim will be replaced with another randomly sampled claim from that State's universe for the PERM review. In the event re-sampling is no longer possible due to timeline constraints, the SC will discard the claim(s) from the sample.

Exhibit 1 – Sample Provider Attestation

Dear Sir/Madam:

Due to extenuating circumstances beyond my control, I am unable to provide the requested medical documentation in support of my Medicaid/SCHIP claim, CID number_____ (please include CID number).

I attest that the medical record documentation was:
__ completely destroyed on _____(please include date).
__ partially destroyed on _____(please include date); however, I am providing any remaining medical record documentation.

The medical record documentation was destroyed by:
__ flood
__ fire
__ hurricane
__ other _____.

Under penalty of law, I declare to the best of my knowledge and belief, that the information I have provided is true, correct, and complete.

Please fill-in the following information:

Printed Full Name: _____

Signature: _____

Title: _____

Date of Signature: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

Please return form to: PERM Database and Documentation Contractor