



Payment Error Rate Measurement Program
c/o Livanta LLC
CMS Documentation & Database Contractor
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

FY 2009

Payment Error Rate Measurement Program

Medicaid and SCHIP

Fee-For-Service and Managed Care Claims

Detail

Data Submission Instructions

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FY 2009 PERM Detail Data Submission Instructions

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Section One

INTRODUCTION

Section 1: Introduction

Purpose

The purpose of the Payment Error Rate Measurement (PERM) program is to estimate state-level payment error rates and, from these, national-level payment error rates for Medicaid and the State Children's Health Insurance Program (SCHIP). The error rates will be based on reviews of Medicaid and SCHIP Fee-For-Service (FFS) and Managed Care payments made in the fiscal year under review, as well as eligibility reviews for the same fiscal year. States will conduct eligibility reviews and report eligibility-related payment error rates. See the Glossary for definitions of the terms used throughout this guide as applied to the PERM program.

The Centers for Medicare & Medicaid Services (CMS) announced in the October 5, 2006 interim final regulation that, in response to public comment, it will adopt a national contracting strategy to measure improper payments in the Medicaid and SCHIP program to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). The national contracting strategy involves three contractors: a statistical contractor (SC), a documentation/database contractor (DDC), and a review contractor (RC). CMS has selected Livanta LLC as the SC, Livanta LLC as the DDC, and Health Data Insights (HDI) as the RC for FFY 2009 PERM.

As the SC, Livanta's primary responsibilities are to:

- Receive and review the universe of line items/capitation payments from each state
- Review state eligibility sampling plans and collect eligibility-related error rates from the states
- Sample FFS line items and Managed Care capitation payments on a quarterly basis, which is done through the following steps:
 1. Determine the sample size of line items/capitation payments that will be reviewed for each state
 2. Select a random sample of line items/payments from the universe extract files provided by the state each quarter
 3. Forward the sample selected to the DDC
- Collect medical review and payment processing error findings from the review contractor for claims/capitation payments
- Calculate each state's Medicaid and SCHIP program error rates using findings from the medical reviews, processing reviews, and eligibility reviews and calculate national error rates for Medicaid and SCHIP for FY2009 based on the states' error rates

As the DDC, Livanta's primary responsibilities are to:

- Request additional details and adjustments for the sampled records from the states and compile the claim details into a standardized format

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- Request state Medicaid and SCHIP medical policies from the states
- Request medical records for sampled FFS paid claims from the providers
- Forward the standardized claims details, medical policies, and medical records to the RC

As the RC, HDI's primary responsibilities are to:

- Use the medical policies and medical records obtained by the DDC to perform the medical reviews
- Perform data processing reviews, either on-site at the state's claim processing facility or through remote access
- Provide its medical and data processing review findings to the SC
- Participate with the SC in writing the final error report

Data Needs of CMS Contractors

The states and the PERM contractors will work to prepare universe files with Medicaid and SCHIP claims, sample from the universe files, and then gather details on the sampled claims. Below is a brief overview of how each contractor uses the data.

- The SC will draw a random sample from the quarterly universe files submitted by the states.
- The DDC is responsible for collecting the information needed by the RC to accomplish the processing and medical reviews of the selected sample claims.
 1. The DDC will request the additional claim and line details for the selected samples and upon receipt of the detail information, compile the data into a standardized format for the RC. The data elements included in these claim details will include beneficiary and provider information associated with the sampled claims, as discussed below and in Section 3.
 2. The DDC will request the records supporting the sampled FFS paid claims. (Records will not be requested for denied claims, managed care claims, Medicare crossover claims, or FFS fixed premium payments unrelated to a medical record such as a Primary Care Case Management (PCCM) monthly fee.) To request these records, the DDC requires states to provide sufficient information within the sampled claims detail data to permit the DDC to identify the patient and date of service and to contact the servicing and/or billing providers to request the record. The more detail that is provided by the state regarding the billing provider, servicing provider, diagnoses, procedures, and beneficiary, the easier it is for the provider to identify the proper records and return them to the DDC within the 60 day timeframe. Records that cannot be obtained from the provider within 60 days are counted as payment errors due to no documentation for PERM purposes. These instructions discuss the required data elements for the sampled claim and line items in more detail in Section 3.

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3. The DDC will also request from the states copies of Medicaid and SCHIP program policies (e.g., payment policies, benefit coverage policies) to assist the Review Contractor in its medical reviews.
- The RC is responsible for medical review and claims processing review for FFS payments and a processing review for Managed Care. The RC will receive from the DDC the standardized claim and line item detail associated with the sampled claims and the records received from FFS providers. For the medical review, the RC will refer to the claims data in combination with the record and the coverage and benefit policies provided by each state.

To accomplish the FFS processing review, the RC needs not only the history and detail for each of the sampled claims, but also information from the beneficiary file (or subsystem) and provider files (or subsystems) and copies of the states' payment policies and fee schedules. The beneficiary files will include third party liability (TPL) information, spend down indicators, eligibility history, aid category (which will help determine copayment expectations and benefit coverage), and enrollment in other Medicaid programs (e.g., home and community-based waiver). This beneficiary information impacts claim payment policies, benefit limitations, etc. Provider file data will establish rules regarding application of fee schedules, authorization for provision of certain services, etc.

For the Managed Care processing review, the RC will need a unique record ID, the Managed Care plan identifier, amount and date paid, type of payment (e.g., monthly capitation, delivery kick payment), capitation payment period, type of payment and sufficient information on the beneficiary to establish the accuracy of the payment rate, such as beneficiary ID, beneficiary date of birth, gender, county/service area indicator of managed care region and aid category.

The information needed by the RC to accomplish the processing and medical reviews will largely come from the DDC, although the processing review will be finalized either on site at the state's claims processing unit or fiscal agent, or through remote access to the state's payment system.

Section Two

OVERVIEW OF THE SAMPLING PROCESS

Section 2: Overview of the Sampling Process

Each state submits a universe extract to the SC of all beneficiary-specific payments for each of the following four program areas:

- Medicaid FFS (further broken down into record request FFS and fixed premium payments)
- Medicaid Managed Care
- SCHIP FFS (further broken down into record request FFS and fixed premium payments)
- SCHIP Managed Care

The extracts must include the required data elements and conform to the specifications in the Universe Data Submission Information Package provided by the SC. From each of these program areas, the SC selects a random sample of claims, line items, or payments from the universe data, as applicable to each state.

The DDC then requests details for the sampled claims from the state. An example of the Data Request Instruction Sheet that will be included in a state detail claim request package is included in Appendix A. The state provides detailed claim and line information for each sampling unit, including adjustments made within 60 days of the original paid date. Standardized claim detail layouts are included in this package as a separate Excel spreadsheet attachment.

The state returns the sampling unit details to the DDC, who will standardize the format and return it to the state after forwarding to the RC. For the Managed Care and fixed premium payment sampled records, the state only needs to return to the DDC any adjustments made within 60 days of the original paid date.

The DDC reviews the sampled claim details and adjustments, converts the data into a standard format, and forwards the claims to the RC. The RC will review the sampled claims and payments for errors and will determine the dollar amounts of the errors. The SC will use RC's findings to calculate an error rate for each program area.

Section Three
CLAIM AND LINE
DETAILS DATA
REQUIREMENTS FOR
DDC

Section 3: Claim and Line Details Data Requirements for DDC

Sample Detailed Claims Data: Medicaid and SCHIP FFS

In its Medicaid and SCHIP FFS universes, the state will submit an extract of the claims information for all adjudicated sampling units (paid claims and denials) for each quarter. From the universe claims extract, the SC will select a random sample and the DDC will request details from the states.

Information to Include in the Sampled Claims Details Data

States will return to the DDC detailed information on each sampled item within two weeks from receipt of the sample identifiers. The detailed information includes:

- Complete claim information: This includes both header-level information and information on all details or lines associated with the claim of the sampled unit. For example, if line 2 of a claim is sampled, the information returned by the state should include information from the header and data on all lines associated with that claim header (not just the sampled line). Likewise, if the sampling unit is sampled at the claim header level, all lines and/or revenue codes associated with that claim header must be returned by the state.

Claim details will include all fields necessary for the DDC to request a record and for the RC to conduct a processing and record review. The DDC has developed two file layouts for FFS sampled claims. These file layouts are contained in the Excel spreadsheet titled *5-2009 PERM Standard Claims Data Formats_022509-Final* and include:

- 1) A list of required fields for most services paid in the state's claims processing system (e.g., health services); these claims are those for which Livanta DDC requests documentation from the provider. The file layout for these FFS claim details is contained in worksheet 1 of the spreadsheet *5-2009 PERM Standard Claims Data Formats_022509-Final*, titled FFS Claim Dtls 2009.
 - 2) A list of required fields for "fixed premium payment" (FPP) adjustments. These represent premium payments and other capitated, non-managed-care claims that are tied to a specific beneficiary yet are not service-specific. Because the state submitted in its fixed premium payment universe all of the necessary data elements for original fixed premium payment records, the state only needs to submit details for FPP adjustments made within 60 days of the original sampled payment record. The file layout for the FPP adjustments is contained in worksheet 2 of the spreadsheet *5-2009 PERM Standard Claims Data Formats_022509-Final*, titled FP-MC Adj 2009.
- Claim history: For record request FFS sampled claims, the sampled unit plus any adjustments made within 60 days of the original paid date (see the next section for

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details). For FPP adjustments, the state only needs to return details for any adjustments made within 60 days of the original record's payment date, and

- **Provider information:** The DDC would like to have the billing and the performing provider identifier on all record request FFS claims in the sample, along with these providers' addresses and telephone numbers. The more up-to-date the state's provider contact information is, the better the chances are the documentation supporting the claims can be obtained. Claims with no documentation submitted are considered payment errors for the full amount of the sampling unit with no opportunity for difference resolution.

It is important that the state take time to review its provider information when submitting details to validate that the provider associated with each claim is who should be contacted for obtaining the record that supports the claim. Be mindful of instances where the billing provider in Medicaid Management Information System (MMIS) is a state agency or other organization; the state may need to dig a level or two down to find out who actually rendered the service and maintains the record. The state would then need to include the rendering provider information in the details associated with that claim.

The DDC also requests that the state indicate, when sending its claim details, which provider (billing or performing) is most likely to have the documentation that supports the claim. This may vary by claim type for each state.

For all states, complete claim and line details for each sampling unit ***should be returned to the DDC within two weeks of receipt of the sample*** by the state. The Claim Detail Data Transmission Instructions subsection provides details for transmitting the sample data to the DDC, including suggestions for quality control steps the state should take to ensure that these data requirements are followed.

Adjustments

The PERM August, 2007 final regulation requires that the PERM review contractor consider all adjustments made within 60 days of the original paid date. The CMS contractors will consider the net amount paid (original paid amount with additions/subtractions due to adjustments that occurred within 60 days) in calculating the error rate.

States will submit adjustments along with the other details for claims and lines selected in the random sample each quarter. After receiving the sampling unit list, the state will compile adjustments that occurred within 60 days of the original paid date for each sampled item, and return this information to the DDC along with the remaining claim and line details within two weeks of receiving the sample.

The DDC understands that different MMIS' maintain different levels of historic detail on adjustments and will work with states to identify mechanisms and data fields to appropriately account for adjustments.

Note that while most states have policies that allow adjustments to be made more than 60 days after the original paid date, only the adjustments made within 60 days should be provided for PERM purposes. If more adjustments are included, the state must provide the DDC enough information to be able to remove any adjustments made beyond that 60 day limit.

Sample Detailed Claims Data: Medicaid and SCHIP Managed Care Adjustments

Details

When submitting the managed care universe, states will be asked to submit complete payment information for all adjudicated sampling units for the Managed Care universes for each quarter, with all fields necessary for the RC to conduct a processing review. The SC will select a random sample, and then the DDC will ask the states to return any adjustments to sampled managed care records within two weeks of receiving the sample from the DDC.

For all sampled Managed Care payments, the state will return only adjustments made within 60 days of the original paid date, using the file layout contained in worksheet 2 of the spreadsheet *5-2009 PERM Standard Claims Data Formats_022509-Final*, titled FP-MC Adj 2009

Adjustments

The PERM August 2007 final regulation requires that adjustments made within 60 days of the original paid date to be included in the review process, which will consider the net amount paid (original paid amount with additions/subtractions due to adjustments that occurred within 60 days) in calculating the error rate.

States will submit adjustments for managed care payments selected in the random sample each quarter. These may include retroactive rate changes, rate cell assignment corrections, and takebacks for beneficiaries who lost eligibility after cut-off, moved, or died, or other situations.

After the SC has randomly selected the sample and the DDC has sent the list of sampled records back to the state, the state will compile adjustments that occurred within 60 days of the original paid date for each sampled item, and return this information to the DDC within two weeks of receiving the sample.

Note that while most states have policies that allow adjustments to be made more than 60 days after the original paid date, only the adjustments made within 60 days should be provided for PERM purposes.

Claim Detail Data Transmission Instructions

Data Submission Media

The DDC will accept details for sampled claims on CDs and DVDs, appropriately labeled. (See Section 4, Data Security.) The state may also FTP claim details to the DDC's secure FTP site; the DDC has separate FTP instructions which can be provided upon request.

Data Submission Formats

The state may submit the claims and lines in the standardized format provided by the DDC, or in a consistent state format that meets the requirements. (See the related layout spreadsheet included in this communication: *5-2009 PERM Standard Claims Data Formats_022509-Final*.)

The DDC strongly prefers that data be submitted in SAS datasets, tab-delimited text files, or an Excel spreadsheet.

Quality Control

Sample Quality Control-Record request FFS

- Information is included for every sampling unit
- All required fields are included.
- Claim headers and all details (including the sampled line item and all other line items associated with the same claim or all line items associated with the sampled claim) are included for each sampling unit.
- Adjustments within 60 days of the original pay date are included for each sampled claim (including all line items associated with the same claim header).
- Records are in the specified layout/format in a separate file.
- All fields necessary to identify and apply adjustments are included.

Managed Care and Fixed Premium payment Adjustments to Sampled Payments

- Adjustments within 60 days of the original pay date are included.

Transmission Information

Prior to the initial claims submission, the DDC will collect state data dictionaries and decode values for requested data elements. For example, if the state uses local provider type codes, the DDC will request the state provide the provider type definitions associated with the codes. Additionally, if the state's ICN or TCN has embedded logic (e.g., the first two digits reflect claim submission media), the DDC will request the state submit the ICN logic.

When the state submits their claim and line details to the DDC, they should list each file contained on the CD/DVD and a total record count for each file. The file should identify the program (Medicaid or SCHIP) and FFS or Managed Care. It is advised that this information be sent in an email to the DDC and the printed email can then be included in the envelope with the CD/DVD. This method has the benefit of alerting the DDC as to when to expect data from the state.

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DDC Mailing Address

Address Information for Claims Details Submission:

Mailing Address: PERM DDC
Livanta LLC
9090 Junction Drive
Suite 9
Annapolis Junction, MD 20701

Email Address: papplegate@livanta.com

Section Four

DATA SECURITY

Section 4: Data Security

Data will be obtained from states via secure electronic media. The DDC's data systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, cartridge tapes, portable hard drives). The DDC expects that most states will send their data on CDs.

States are asked to comply with HIPAA Privacy and Security Rules, CMS Business Partners Systems Security Manual rules for sensitive data transfer and their own state privacy and security rules. Any media that contains sensitive data should be labeled "CMS Sensitive Information".

States should password protect the data stored on the media.

States should send electronic media via a private overnight delivery service (such as FedEx or UPS) or USPS and mark "To be opened by addressee only." Data containing electronic personal health information (EPHI) should not be emailed. Passwords and data documentation including file names, record layouts, and data definitions should be sent to The DDC by mail or email.

Password information must be sent separately from the data.

The DDC will transmit data to states. The DDC will password protect and encrypt all datasets using the encryption option in zip software. If FFS sample data does not include electronic private health information (EPHI), it will be sent to states by email. Data with EPHI, including FFS full claims and Managed Care data, will be burned onto CDs and labeled "CMS Sensitive Information." CDs will be sent via FedEx and marked "To be opened by addressee only." In all instances, passwords will be sent separately. The DDC will also send an email notifying the state that data has been sent to them and asking the state to verify that they received the data.

GLOSSARY

Glossary

Definitions

Adjudicated Claim: In reference to denied claims, an adjudicated claim is one that has been accepted and reviewed by the claim processing system and the decision to deny the claim has been made. In reference to paid claims, an adjudicated claim refers to a submitted claim that has been accepted and fully reviewed and a positive determination has been made regarding the payment amount. For denied claims, the adjudication date should be used to determine whether a claim is included in a fiscal quarter if the state system does not capture a “paid date” for these claims. For paid claims, the date paid should be used for this determination.

Adjustment: Change to a previously submitted claim that is linked to the original claim.

Capitation: A fixed payment, usually made on a monthly basis, for each beneficiary enrolled in a managed care plan or for each beneficiary eligible for a specific service or set of services.

Claim: A request for payment, on either an approved form or electronic media, for services rendered generally relating to the care and treatment of a disease or injury or for preventative care. A claim may consist of one or several line items or services.

Denied claim or line item: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment and not approved for payment in whole or in part.

Fee-For-Service (FFS): A traditional method of paying for medical services under which providers are paid for each service rendered.

FFS processing error: A payment error that can be determined from the information available from the claim or from other information available in the state Medicaid/SCHIP system (exclusive of medical reviews and eligibility reviews).

Health Insurance Premium Payment (HIPP): A program allowing states to choose to have Medicaid or SCHIP pay beneficiaries’ private health insurance premiums when it is more cost-effective than paying for the full cost of Medicaid or SCHIP services.

Individual Reinsurance: In the context of PERM managed care universe files, individual reinsurance payments are those payments made by the state to a Managed Care plan for an individual beneficiary whose cost of care has exceeded a predetermined maximum amount, usually measured on an annual basis or on the basis of a specific episode of care. Such payment by the state typically represents a cost sharing arrangement with a Managed Care plan for extremely high-cost enrollees. Individual reinsurance may be based on the costs associated with all services provided by the Managed Care plan, or may be limited to excessive costs associated with certain services (e.g., transplants). (Note: providers whose payment rates are fully reconciled for actual costs incurred, on a retrospective basis, are considered to be FFS.)

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Kick Payment: A term used in reference to a supplemental payment over and above the capitation payment made to Managed Care plans for beneficiaries utilizing a specified set of services or having a certain condition.

Line item: An individually-priced service presented on a claim for payment. Items individually listed but priced in a bundled service rather than being priced individually are not considered “line items.”

Managed Care: A system where the state contracts with health plans on a prospective full-risk or partial-risk basis to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for services delivered.

Managed Care Organization (MCO): An MCO is an entity that has entered into a risk contract with a state Medicaid and/or SCHIP agency to provide a specified package of benefits to Medicaid and/or SCHIP enrollees. The MCO assumes financial responsibility for services delivered and is responsible for contracting with and reimbursing servicing providers. State payments to MCOs are typically done on the basis of a monthly capitation payment per enrolled beneficiary.

Medicaid: A jointly funded federal and state program that provides health care to people with low incomes and limited resources.

Medicaid Statistical Information System (MSIS): The MSIS, housed by CMS, collects statistical data from each of the states on an annual basis (using form HCFA-2082). The system includes aggregated statistical data on recipients, services, and expenditures during a Federal fiscal year (i.e., October 1 through September 30).

Medical review error: An error that is determined from a review of the medical documentation in conjunction with state medical policies and information presented on the claim.

Medicare: The federal health insurance program for people 65 years of age or older and certain younger people with disabilities or End Stage Renal Disease. Beneficiaries must pay (or have paid on their behalf) premiums for the two main portions of Medicare: Part A (hospital) and Part B (physician) services.

Non-claims based sampling unit: Sampling units that are not related to a particular service provided, such as Medicare Part A or Part B premiums.

Overpayment: Overpayments occur when the state pays more than the amount the provider was entitled to receive or paid more than its share of cost.

Paid claim: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, determined to be a covered service eligible for payment, and for which a payment was issued or was determined to result in a zero payment due to circumstances such as payment by a third party insurer.

Partial error: Partial errors are those that affect only a portion of the payment on a claim.

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Primary Care Case Management (PCCM): A program in which beneficiaries are linked to a primary care provider who coordinates their health care. Providers receive small additional payments to compensate for care management responsibilities, typically on a per member per month basis. Providers are not at financial risk for the services they provide or authorize.

Risk-based Managed Care: The Managed Care organization (MCO) assumes either partial or full financial risk, and is paid a fixed monthly premium per beneficiary.

Sampling unit: The sampling unit for each sample is an individually priced service (e.g., a physician office visit, a hospital stay, a month of enrollment in a managed care plan or a monthly Medicare premium). Depending on the universe (e.g., fee for service or managed care), the sampling unit includes: claim, line item, premium payment, or capitation payment.

Stop-loss: See “Individual Reinsurance,” above.

Supplemental payments for specific services or events: These are payments that may be made by the state to a Managed Care organization on behalf of a particular enrollee in the managed care plan, based on the provision of a particular service or the occurrence of a particular event, such as childbirth.

Third Party Liability (TPL): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. In cases of available TPL, Medicaid is payer of last resort.

Underpayment: Underpayments occur when the state pays less than the amount the provider was entitled to receive or less than its share of cost.

Universe: The universe is the set of sampling units from which the sample for a particular program area is drawn and the set of payments for which the error rate is inferred from the sample. The term “claim” is used interchangeably with the term “sampling unit.”

Zero-paid claim: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and approved for payment, but for which the actual amount remitted was zero dollars. This can occur due to third-party liability, application of deductibles, or other causes.

APPENDIX

FY 2009 PERM Detail Data Submission Instructions

APPENDIX A
SAMPLE STATE DETAIL CLAIM REQUEST PACKAGE

Instructions to the state for returning 2009 PERM details to the DDC:

Steps	Description	Reference
1. Review Sampler Data Package received from the DDC.	Contact the DDC if you have any questions.	Tawney Moreno tmoreno@livanta.com 240-568-9434 x230
2. Work with the DDC to set up an orientation conference call. This orientation does not occur each time you receive a sampler file—only at the beginning of the PERM cycle.	The purpose of the call is to go over the 2009 claim detail layouts, data idiosyncrasies, and answer any questions. The DDC will be contacting you to schedule the call.	Crystal Hampton champton@livanta.com 240-568-9434 x223
3. For Fee for Service (FFS) requests, create a file for the details and adjustments for each sampling unit contained in the Sampler file(s) in this data package.	Extract all requested fields for the header and all lines for the complete claim associated with each sampling unit in the Sampler file. Include original claim detail and any adjustments that occurred within 60 days of the sampling unit's payment date. Don't forget to assign the PERM_ID based on the sampler file!	Requested fields and suggested layouts are defined in the attached Standardized 2009 PERM Data Layouts.
4. For Fixed Premium Payment and Managed Care (MC) sampled payment records, create a file for the adjustments for each sampling unit contained in the Sampler file(s) in this data package.	Include details for any adjustments that occurred within 60 days of the sampling unit's payment date.	Requested fields and suggested layouts are defined in the attached Standardized 2009 PERM Data Layouts.
5. Update the data dictionary to indicate the reason any requested fields cannot be provided. Indicate any fields not requested that you are providing.	For example, performing provider data is not provided because it is not contained in your system; or level of care is crucial to your LTC processing and is therefore included in your extract.	Standardized 2009 PERM Data Layouts

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<p>6. Send claim details and adjustments to the DDC.</p>	<p>Data can be submitted via:</p> <ul style="list-style-type: none"> • Secure FTP (The DDC will provide instructions) • CD (Send to the DDC via FedEx or UPS or some type of trackable mail. Note the password for the file in the PERM Data transmission sheet). 	<p>2009 PERM Claim Detail Data Submission Instructions. The DDC strongly prefers that data be submitted in SAS datasets, tab-delimited text files, or an Excel spreadsheet. Our process uses SAS.</p>
<p>7. Complete PERM Data Transmission Sheet</p>	<p>Fill in requested items and email to the DDC.</p>	<p>Transmission sheet is in 2009 PERM Data Request Package Info & Forms.</p> <p>Email to Crystal Hampton at champton@livanta.com</p>

Mail CD with files to:

Pam Applegate
Program Director
PERM DDC
c/o Livanta LLC
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701