PERM Data Processing (DP) State System Questionnaire – FY 2017
Cycle 3 Measurement

Purpose: The purpose of the PERM DP State System Questionnaire is to obtain essential information from the state to assist the Review Contractor (RC) in completing DP reviews. This information is critical to ensuring a successful DP review process and increasing the possibility of finding cases error-free. Questions focus on the following topics.

- State Information
- General System Information
- Beneficiary Information
- Provider Information
- Claim Payment Information
- Managed Care
- Waiver Claims

Instructions: Complete Sections 1-7 of this questionnaire electronically, using the form fields provided.

You will need to complete a separate questionnaire for each system that will need to be reviewed for the PERM sample.

1. State Information

State:	**Select State**
Supporting System(s) Name:	
System Defined Name:	
Date:	Click here to enter a date.
Claim Types Processed:	
Program:	**Select Program**

2. General System Information

1. Does the state have the capability to allow the reviews to be conducted remotely via a secure VPN connection (Citrix, Cisco, Juniper, etc.)? If not, please provide an explanation outlining the system limitations preventing remote access.
Click here to enter text.
2. Will the state allow the PERM audit, or at minimum specific components of the PERM audit, to be conducted remotely?
Click here to enter text.
3. If reviews are conducted onsite, will reviews be completed in one location or multiple locations? Please provide the address and state contact for each location where reviews will be conducted.
Click here to enter text.
4. Will reviewers be granted rights to access all applicable systems, including the document/image repository, used for the administration of the state Medicaid/CHIP program for the PERM audit?
Click here to enter text.
5. If your answer to Question # 4 is not an unconditional "Yes," please identify all such system(s) to which reviewers will not be granted access, describe in detail any factors you believe necessitate denying the reviewers the right to access such systems, as well as the state's plan to provide the reviewers primary access to such systems of record data.

Click here to enter text.
6. Is there a maximum number of reviewers that the state will grant remote or onsite access?
Click here to enter text.
7. Please describe any factors that the state believe require them to limit the number of reviewers to whom they will grant access.
Click here to enter text.
8. Please list all criteria options available for use in performing claim inquiry and accessing claim information. (e.g., claim number, beneficiary number, provider number, provider type, date of service, procedure code, etc.)
Click here to enter text.
9. Please define the structure of the claim number. (e.g., Julian date, batch number, sequence number, media, etc.)
Click here to enter text.
10. Does the claim number contain data elements that the state has classified as PHI/PII? (e.g., beneficiary number, DOB, etc.)
Click here to enter text.
11. Does the claim number contain any “smart” elements that impact processing logic? (e.g., data that results in the bypass of predetermined adjudication edits)
Click here to enter text.
12. How is the claim source/media defined and identified on the claim? (e.g., paper vs. electronic submission)
Click here to enter text.
13. How is the claim version defined and identified on the claim? (e.g., original, adjustment, void, paid, denied)
Click here to enter text.
14. How is the transaction type defined and identified on the claim? (e.g., individual claim for payment, encounter, gross payout)
Click here to enter text.
15. Are images of paper claims available in the payment system or an imaging system? If so, will the reviewer have direct access to the system to retrieve claim images? If not, will copies of paper claims be made available?
Click here to enter text.
16. Are facsimiles of electronic claims available in the payment system or an imaging system? If so, will the reviewer have direct access to the system to retrieve facsimile images? If not, will the reviewer have access to the incoming electronic data file?
Click here to enter text.
17. If the reviewer is required to access the incoming data file for validation, does the state utilize an application or have a process in place to parse the data?
Click here to enter text.
18. Does the state capture all data submitted on the electronic transaction or is capture limited to the data required for adjudication?
Click here to enter text.
19. If the electronic data capture is limited to the information required for claim adjudication, is the state aware of any omissions that are a required review element of the PERM audit which may result in an error (e.g., NPI submitted on an electronic institutional claim but not captured and displayed on the claim record in MMIS)?
Click here to enter text.

20. Which date in the state system (adjudication, voucher, remittance advice, etc.) was used as the paid date in your PERM universe submission?
Click here to enter text.
21. How long do claims remain visible in the payment system?
Click here to enter text.
22. Are claims purged from the payment system at specific intervals? If so, the state will need to provide electronic or hard copy documentation of all purged claims sampled.
Click here to enter text.
23. How are claims identified in the system as being funded by Title XIX (Medicaid) or Title XXI (CHIP)? For example, does the claim include a funding code or does the beneficiary aid category define this information? Please provide a list of valid funding codes and aid category codes for Title XIX/Title XXI.
Click here to enter text.
24. Does your state pay for pregnant undocumented women with Children's Health Insurance Program (CHIP) (Title XXI) funds?
Click here to enter text.
25. If your answer to Question # 23 is "Yes," are only pregnancy-related services covered up until birth?
Click here to enter text.
26. If your answer to Question # 24 is "Yes," please provide the approved State Plan Amendment (SPA) from CMS.
Click here to enter text.
27. Are the Medicaid State Plan and State Plan Amendments available online? If so, please provide the URL.
Click here to enter text.
28. Does the system contain valid values tables (eligibility aid codes, county codes, third-party liability coverage codes, categories of service, provider types, provider specialties, provider risk level, claim types, etc.)? If not, please provide electronic copies of this information.
Click here to enter text.
29. Does your system contain data field assistance or a help function? If so, how is the help function accessed?
Click here to enter text.
30. Does your state have an online systems manual or training manual that you can provide? If so, please provide the URL. If not available online, please provide an electronic copy.
Click here to enter text.
31. Does your state have an online electronic submission companion guide that you can provide? If so, please provide the URL. If not available online, please provide an electronic copy.
Click here to enter text.
32. Does your state have an online provider billing manual that you can provide? If so, please provide the URL. If not available online, please provide an electronic copy.
Click here to enter text.

3. Beneficiary Information

1. Are there beneficiaries that are not in the eligibility system?
Click here to enter text.

2. If there are beneficiaries that are not in the eligibility system, is the state able to provide hard copy documentation which verifies the eligibility determination other than the claims processing system?
Click here to enter text.
3. Is the beneficiary's date of death contained in the eligibility system, claim payment system, or both?
Click here to enter text.
4. How is the state notified of a beneficiary's death?
Click here to enter text.
5. Does your state run routine checks against the Social Security Administration's Death Master File to check for deceased beneficiaries? If so, how often are these checks done?
Click here to enter text.
6. Is the beneficiary's citizenship/alien (undocumented) status contained in the eligibility system, claim payment system, or both? What is the screen name?
Click here to enter text.
7. Is the beneficiary's living arrangement contained in the eligibility system, claim payment system, or both? What is the screen name?
Click here to enter text.
8. Will your state provide direct access to the beneficiary eligibility source system(s) or will the beneficiary eligibility information be provided by a report?
Click here to enter text.
9. How many eligibility systems send beneficiary eligibility information to the claims payment system(s)? How often is this information transmitted?
Click here to enter text.
10. How many systems determine eligibility for Medicaid and CHIP? Please list the names of each system.
Click here to enter text.
11. Are the beneficiary's current and historical eligibility spans contained in the eligibility system, claim payment system, or both? What is the screen name?
Click here to enter text.
12. Are the beneficiary's current and historical Medicare eligibility spans contained in the eligibility system, claim payment system, or both? What is the screen name?
Click here to enter text.
13. Are Specified Low-income Medicare Beneficiaries, Qualified Medicare Beneficiaries, and Q-1 Beneficiaries current and historical eligibility spans contained in the eligibility system, claim payment system, or both? What is the screen name? If not, where is this information contained? What is the screen name?
Click here to enter text.
14. How are adjustments for Medicare premium payments processed when beneficiaries are determined to be no longer eligible for Medicare buy-in benefit?

Click here to enter text.
15. Is the beneficiary's current and historical Medicare premium buy-in information contained in the eligibility system, claim payment system, or both? What is the screen name?
Click here to enter text.
16. Are the beneficiary's current and historical managed care enrollment spans contained in the eligibility system, claim payment system, or both? What is the screen name?
Click here to enter text.
17. Does your state have a cost avoidance policy for TPL? Are there any exceptions (absent parent, liability claims, or other federal exemptions)? If there are exceptions other than the federal exemptions, please provide an approved SPA or exception letter from CMS.
Click here to enter text.
18. Is detailed information available about known TPL (i.e., coverage types, absent parent ID, begin and end dates, etc.)?
Click here to enter text.
19. Will reviewers be able to determine when the TPL information was added to the state system? What is the screen name?
Click here to enter text.
20. Do the beneficiary screens contain Health Insurance Premium Payments and/or Primary Care Case Management eligibility? Does the system record the history of payments? What is the screen name? If not, how will these payments be identified and where can reviewers find documentation to support these payments?
Click here to enter text.
21. Are the beneficiary's current and historical share of cost amounts contained in the eligibility system, claim payment system, or both? What is the screen name?
Click here to enter text.
22. Is beneficiary share of cost prorated each month or is it deducted from the first billing of each month? If prorated, please provide the formula used.
Click here to enter text.
23. Does your state edit against the table of beneficiary share of cost or accept what is reported by the provider?
Click here to enter text.

4. Provider Information

1. How many vendors support the state program by claims adjudication? Identify all such vendors and describe what type(s) of services each such vendor adjudicates.
Click here to enter text.
2. Are there multiple vendors responsible for provider enrollment? If so, identify all vendors who have provider enrollment responsibility.
Click here to enter text.

3. Are the provider's current and historical records of enrollment effective dates (with valid begin and end dates) contained in the system? What is the screen name?
Click here to enter text.
4. Does the state require the NPI for all applicable providers to be submitted on all claims, as required by federal regulation and HIPAA 5010 transaction standards for 837I, 837P, 837D, and Pharmacy POS? This includes Billing, Attending/Rendering/Servicing/Furnishing and Referring/Ordering/Prescribing.
Click here to enter text.
5. Does the state apply the HIPAA 5010 standards to paper claim submissions during adjudication? (e.g., does the state require the submission of the attending provider's NPI on institution claims submitted on paper?)
Click here to enter text.
6. Does the state require the submission of the furnishing provider on professional claims, dental claims, or both? If so, does the state require the Type 1 (individual) NPI or the Type 2 (organizational) NPI be submitted on the claim?
Click here to enter text.
7. Are the provider's current and historical records of licensure, certification, and CLIA effective dates (with valid begin and end dates) contained in the system? What is the screen name?
Click here to enter text.
8. How is the state notified of updates to provider licensure, certification, and CLIA effective dates?
Click here to enter text.
9. Are the provider's current and historical records of type and specialty contained in the system? What is the screen name? Is this information also listed on the claim?
Click here to enter text.
10. Are the provider's current and historical records of sanction periods contained in the system? What is the screen name? Does your state routinely match to the Office of the Inspector General's Excluded Entities list?
Click here to enter text.
11. Please provide the date your state implemented the ACA risk-based screening requirements for newly-enrolled providers.
Click here to enter text.
12. Does the state rely on PECOS or any other state's enrollment and risk-based screening results in lieu of performing screening activities required for provider enrollment?
Click here to enter text.
13. Has your state begun the revalidation process? If so, please provide the date your state began the revalidation process. If not, did your state provide a notification to the provider community prior to 3/24/2016 notifying providers of the revalidation requirement and the 9/24/2016 extended revalidation date?
Click here to enter text.
14. Is the provider revalidation date separately referenced in the provider file? If so, what is the screen name? Is there a specific code or indicator that designates the date as revalidation, reenrollment, new enrollment, etc.?
Click here to enter text.
15. If a notice of the revalidation requirement was given to providers prior to 3/24/2016 advising of the 9/24/2016 extension date, what method was used for the notification? Please provide the URL if the notification was made electronically or provide a copy of the notification sent.
Click here to enter text.

16. Does the provider file contain documentation of the completion date of the required database checks, site visits, finger printing, and criminal background checks? What is the screen name? If this information is not in the system, how will the state provide the documentation for verification?
Click here to enter text.
17. Does your state identify risk levels by provider type or individual provider? Does the provider file list the assigned risk level? What is the screen name?
Click here to enter text.
18. Does your state have documentation that outlines provider types that are required to be licensed and/or certified? Is this information available online? If so, please provide the URL. If not, can an electronic copy be provided?
Click here to enter text.

5. Claim Payment Information

1. What is your state's timely filing policy and what are the delayed billing exception rules?
Click here to enter text.
2. Is a list of covered and non-covered services available online? If yes, please provide the URL. If not, can an electronic copy be provided?
Click here to enter text.
3. Does the system contain current and historical rate tables and fee schedules, including the effective dates? What are the screen names?
Click here to enter text.
4. If previous rates are overlaid with newer rates, is an audit trail contained in the system? What is the screen name? If not, can an audit trail be provided?
Click here to enter text.
5. Are there any temporary legislative or budgetary increases/reductions not contained in the system? What is the screen name? If so, can the state provide documentation of the amounts and effective dates for each such increase/reduction?
Click here to enter text.
6. Does the system contain screens that list the parameters (gender, age, dosage, program coverage, etc.) by procedure code, National Drug Code, Diagnosis Related Group (DRG) code, revenue code, etc.? What are the screen names?
Click here to enter text.
7. Is a list of services that require a referral available online? If yes, please provide the URL. If not, can an electronic copy be provided?
Click here to enter text.
8. Are there services for which the state accepts a Plan Of Care (POC), Individual Service Plan (ISP), or other designated treatment plan in lieu of an order, referral, or prescription?
Click here to enter text.
9. If the answer to Question #8 is "Yes", please specify the services for which the POC, ISP, or other designated treatment plan is accepted in lieu of the order, referral, or prescription.
Click here to enter text.
10. Does your state make exceptions to paying more than the provider bills for certain types of claims? If yes, which types of claims? (e.g., in-patient, LTC, Federally Qualified Health Center, Rural Health Clinic, etc.)

Click here to enter text.
11. What is your state's policy for paying Medicare Part A crossover claims? Does your state cover all deductibles and coinsurance for dual eligible beneficiaries or only cover up to the Medicaid allowed amount?
Click here to enter text.
12. What is your state's policy for paying Medicare Part B crossover claims? Does your state cover all deductibles and coinsurance for dual eligible beneficiaries or only cover up to the Medicaid allowed amount per item? If Medicare coinsurance is prorated across all lines in a claim, how is the proration applied?
Click here to enter text.
13. Are in-patient hospitalization claims paid by DRG, Revenue Code, Cost Reimbursement, or Per Diem? Are there any types of hospitals with a special payment setup? If so, describe how these hospitals are identified and how claim payment is calculated.
Click here to enter text.
14. If in-patient claims are paid by DRG, provide the calculation formula and outlier formula (day and cost). Will reviewers be able to view all formula components in the system? What are the screen names?
Click here to enter text.
15. Are LTC per diem rates based on Level of Care or Case Mix? If the Case Mix or rate changes within a month, is the rate prorated?
Click here to enter text.
16. Are hospice rates calculated using a percentage of the LTC Facility rate? If so, please provide the calculation formula. If not, how are hospice rates calculated?
Click here to enter text.
17. Are pharmacy claims adjudicated in the claim payment system, or by an external PBM? If done by a PBM, pharmacy claims will need to be verified in the PBM source system.
Click here to enter text.
18. Does the PBM enroll providers, or are providers enrolled via the MMIS and provider data sent to the PBM? If the PBM performs provider enrollment activities, the state will need to provide proof that the PBM adheres to all enrollment and screening requirements.
Click here to enter text.
19. If pharmacy claims are adjudicated by a PBM, payment will need to be verified in the PBM source system. Will the reviewer be granted direct access to the PBM system? If not, what is the state's plan for providing the reviewer with primary data from the source adjudication system? (e.g., state representative to navigate the PBM system)
Click here to enter text.
20. Is the submitted NPI of the prescribing provider listed on the claim in the payment system (PBM or MMIS)?
Click here to enter text.
21. What are the pharmacy payment formula(s) and dispensing fees?
Click here to enter text.
22. How are brand versus generic drugs identified?
Click here to enter text.
23. Are current and historical preferred drug lists available online? If so, please provide the URL. If not, please provide electronic copies of those in effect during the cycle period.
Click here to enter text.
24. Are Prior Authorization (PA) indicators contained in the system? If not, does the state have a list of codes or services that require prior authorization? If yes, please provide the URL, if available online, or an electronic copy.

Click here to enter text.
25. Does the state system contain detailed information about the prior authorization, including effective dates, service, units, usage, and providers? What is the screen name?
Click here to enter text.
26. Does your state process any claims only for the Federal Financial Participation? (e.g., Medicaid in Public Schools, sister agency claims, etc.)
Click here to enter text.
27. Does the system use normal rounding rules for calculating payments? (e.g., rounding up at five and above and rounding down with a number ending in less than five) How many decimal places does your state use for calculations before rounding or truncating? Is the policy applied consistently across all claim types?
Click here to enter text.
28. Is the copay policy available online? If so, please provide the URL. If not, please provide an electronic copy.
Click here to enter text.
29. Are there any exceptions for the assessment of copay? (e.g., pregnancy, other specific services or circumstances)
Click here to enter text.
30. Are you currently editing for ICD-10 coding on claims submitted for dates of service 10/01/2015 and after?
Click here to enter text.

6. Managed Care

1. Which populations are considered mandatory managed care and which populations are considered voluntary? Are there any populations that are carved out of managed care?
Click here to enter text.
2. Which counties or regions are considered to be mandatory managed care and which counties or regions are voluntary? Are there any counties in which managed care is unavailable?
Click here to enter text.
3. Is a map or document available that lists managed care plans available by geographical service area (counties)? If so, please provide an electronic copy.
Click here to enter text.
4. Does the system contain managed care rates? If not, please provide an electronic copy.
Click here to enter text.
5. How are rate cells identified? Is this information located in the system? If not, please provide an electronic copy.
Click here to enter text.
6. Is the Managed Care capitation payment made through the payment system (similar to a claim) or paid through a financial transaction by roster?
Click here to enter text.
7. Is reinsurance (stop-loss) calculated for managed care cases that are outside the norm or beyond a predetermined threshold?

Click here to enter text.
8. Do all contracted health plans have the same contract provisions with differences only in rates? Please provide a sample contract.
Click here to enter text.
9. Please provide a list of all non-covered (carve-out) services for managed care (pharmacy, dental, etc.).
Click here to enter text.
10. Are any mental health, dental, or other types of capitation payments separated from the regular health plan capitation payment?
Click here to enter text.
11. Are special capitation payments (kick payments) made for delivery, in-hospital eligibility approvals, etc.?
Click here to enter text.
12. Are retroactive capitation changes made?
Click here to enter text.
13. After a beneficiary becomes eligible, how soon does the managed care plan become responsible? Is there a Fee-for-Service window and, if so, what is the timeframe?
Click here to enter text.
14. What is the policy for paying capitation payments when the beneficiary is born, dies, or changes rate cells in the middle of the month? Is the month of change prorated? What is the prorate formula?
Click here to enter text.
15. What is the process for capitation payments due for periods in which CMS has not yet approved the rate?
Click here to enter text.

7. Waiver Claims

1. Please provide a list of active waivers and a brief description of the covered populations and services covered. If this information is available online, please provide the URL.
Click here to enter text.
2. Are the beneficiary's current and historical records of waiver eligibility contained in the eligibility system, payment system, or both? What is the screen name?
Click here to enter text.
3. Are waiver claims paid through a sister state agency or are individual providers paid directly through the Medicaid system? If waiver claims are paid through a sister state agency, our reviewers will need access to that source system to verify those claims.
Click here to enter text.
4. If waiver claims are paid through a sister state agency, are services submitted using the standard claim format? If so, are the submissions electronic and subject to HIPAA 5010 standards or paper?
Click here to enter text.

5. Please provide a list of waiver services that require a prior authorization. Is prior authorization for these services contained in the system? What is the screen name?
Click here to enter text.
6. Are all rates based on a fee schedule or are some outlined in the individual service plan? If so, please identify the services that are based on the individual service plan.
Click here to enter text.
7. Does your state have any client-employed providers?
Click here to enter text.
8. If your answer to the immediately preceding question is "Yes," are any taxes/insurance premiums (e.g., unemployment, workers' compensation) applied to these types of claims?
Click here to enter text.
9. If your answer to the immediately preceding question is "Yes," please identify the tax rates/insurance premiums that are Title XIX matched and payment methodology for claim payment calculation.
Click here to enter text.

Other Comments

Click here to enter text.