FY 2011 PERM
Data Submission Instructions

Sampled Claim Details Data

Medicaid Fee-For-Service and CHIP Fee-For-Service

SECTION 1: OVERVIEW

This document is a guide for states to collect and submit sampled claim details data to the PERM Statistical Contractor (SC). The overall flow of this process is as follows:

1. The PERM SC will select random samples of payments from the fee-for-service and managed care universe claims extracts provided by the state.

2. The SC will return the sampled fee-for-service claims to the state.

3. For the sampled fee-for-service claims, the state will then provide to the SC a file with details for the sampled payments **within 2 weeks**. This sampled claim details submission will contain information needed to assist the PERM Review Contractor (RC) in requesting records, and the provider in identifying and submitting the medical record associated with each sampled claim.

4. The SC will review the sampled claim details for completeness, standardize the format if necessary, and send the file to the RC to begin the process of requesting medical records.

SECTION 2: SAMPLED CLAIM DETAILS DATA

The details for the sampled claims are used to request medical records and conduct medical review (e.g., verification of service provision in accordance with state policy, confirmation of medical necessity of service, determination of whether the service rendered matches the service codes billed and paid). It is important that they be accurate and complete.

Below we have highlighted some specific aspects of this process that are helpful in submitting a timely, accurate, and complete sampled claim details submission. In Section 4 of these instructions, we have included specific suggestions for checks that states should run on the submission to ensure that it is accurate and complete.

- **PERM ID:** Every sampled payment (i.e., FFS claim, fixed payment, managed care payment) will have a PERM ID that the Review Contractor will use to track that payment. The PERM ID follows a standard logic:

  SS = state
  C/M = CHIP or Medicaid
  11 = year
  ## = quarter
  F/P/M = FFS, fixed payment, managed care
  XXX = three-digit sequential number

  Example: the one-hundred and first fixed payment sampling unit from the Washington, DC 2011 Q1 CHIP universe will have the following PERM ID: DCC1101F101

While the SC will send the samples back to the state in the same format in which we received them, we will add the PERM ID to each record. Please keep track of these PERM ID numbers and include them in the sampled claim details submission.

- **Claim Header and Line Data:** Although in most cases individual line items will be sampled, it may be necessary to review all items on a claim in order to determine the accuracy of the individual line (reviewers will not record errors associated with lines on a claim that were not part of the sample). Therefore, the claims details returned to the SC should include complete header and line information for each sampled claim.

    - If a claim pays on a line basis and the SC sampled line 2, the information returned by the state should include information from the header and **all** lines associated with that claim header, including line 2 and all other lines.

    - If the SC sampled a payment provided in the universe as a header level claim, the state should return in the details submission all lines associated with that claim, as well as the sampled claim header.

    While the state may have provided a header/line indicator in the universe data, the SC may have changed this as part of the universe quality review and sampling process. Please refer to the sampling level field that we have added to each sampled claim. Sampled items indicated by "H" were sampled at the header level, and those indicated by "L" were sampled at the line level. (Sampled items indicated by "F" are "fixed payments" and you do not need to provide additional details for these payments.)

- **Billing Provider vs. Performing Provider**: Identifiers for both the billing provider and the performing provider should be included, along with the providers' addresses and telephone numbers.

    In some cases, such as when the billing provider in MMIS is a state agency or other organization, the state may need to locate additional information on the performing provider and submit the additional information for the associated sampled claim. Please review the sampled claim detail information to validate that the provider information submitted with each sample is the correct provider for the RC to contact to obtain the record that supports the claim.

    Note that if a required medical record cannot be obtained from the provider, the payment will be considered fully in error. Therefore, states are advised to provide complete and up-to-date provider contact information.

Also, please note that there have been some changes to this process from previous cycles.

- **Claim Adjustments Data (adjustment fields and adjustment date):** States are no longer required to submit adjustments with their sampled claim details. The RC will collect any

adjustments made within 60 days to sampled claims during the review process.[1] This applies to both fee-for-service and managed care samples. The RC will work with each state to identify mechanisms and data fields to appropriately account for adjustments during the review.

- **Fields listed in the FY 2088 PERM Data Submission Instructions that are no longer required:**

  - Sampling unit level (the SC will assign the sampling unit level, indicated by H/L/F)
  - Historical ICN
  - Original State ICN
  - Adj indicator
  - Revenue code description

  If a state would like to submit any of these fields, the SC will accept them, but they are not required.

- **Changes to the FY 2011 PERM Data Submission Instructions**

  Some fields listed in the FY 2011 PERM Data Submission Instructions, Appendix B are no longer required. (If you have already set up the programming to submit these fields, the SC will accept them.) These fields include:

  - PERM state (embedded in the PERM ID so not necessary to include in the file)
  - Sample year (embedded in the PERM ID so not necessary to include in the file)
  - Sample quarter (embedded in the PERM ID so not necessary to include in the file)
  - Claim category (this is assigned by the RC)

  We have added additional rows for various codes to accommodate the total number of fields allowed on the UB-92, UB-04, and CMS-1500 claim forms and the 837 transaction file. This includes the following:

  - Increasing the number of ICD-9 procedure codes from 3 to 6
  - Increasing the number of diagnosis codes from 5 to 9
  - Increasing the number of procedure code modifiers from 2 to 4

  If you have already set up the programming to submit only the number of ICD-9, diagnosis or procedure code fields listed in the earlier version of the FY 2011 PERM Data Submission Instructions, please just note that on your data transmission cover sheet.

[1] While state policies generally allow adjustments to be made more than 60 days after the original paid date, only the adjustments made within 60 days will be considered for PERM review purposes, per federal regulation.

We have added the field "Record Type" to the list of fields required in 2011 detailed claims. This code is used to distinguish whether a record is a header or a line level claim. This is an optional field that may facilitate our review of your detail data.

SECTION 3: SAMPLED CLAIM DETAILS FIELD SPECIFICATIONS

Table 1 below lists the fields required in the sampled claim details submission. The SC will work with the state to determine if certain fields are or are not applicable to certain claim or payment types.

Table 1: Required Fields for Details Submissions
Medicaid and CHIP Fee-for-Service

Standard Field Name	Standard Field Description	Notes/Suggestions
PERM ID	Unique indicator for each sampled unit as assigned by SC in the sampled claim file	Populated field will be provided to the state by the SC in the sampled claim file
ICN	Unique claim identifier (e.g., ICN, TCN, other state issued number)	Each record in the PERM universe must be able to be uniquely identified with data elements contained in the record. For "dummy" claims, be sure the ICN information can tie back to the payment in the state's systems If the ICN/Line Number alone is *not* sufficient to uniquely identify the sampling unit, the state must define those fields that can be used to uniquely identify the sampling unit
Claim type	State claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim	State data dictionary required if not provided with universe data
Payment status	Paid or Denied indicator for each claim or claim line.	State data dictionary required if not provided with universe data
Medicare crossover indicator	Indicates that the claim is a crossover claim from Medicare to Medicaid	
Source location	The entity identifier and location of the source that processed the claim.	Required for states that have multiple locations that process claims for the same universe file
Number of line items	The total number of lines associated with the claim	

Standard Field Name	Standard Field Description	Notes/Suggestions
Amount paid header	Total computable amount paid at the claim header	Total Computable Amount = Federal Share + State Share Amount paid should be net of any co-payments, third-party, or other beneficiary liability
Date paid	Date claim was adjudicated or paid; not the check date unless there is no adjudication date. This date should match the paid date submitted in the universe for the sampled claim.	
DOS from Clm	From date of service on the claim	
DOS To Clm	To date of service on the claim	
Beneficiary ID	Beneficiary ID number	
Beneficiary name		State may submit according to state preference (e.g., can submit multiple variables for first, middle, and last name or a single variable containing beneficiary full name)
Beneficiary DOB	Beneficiary date of birth	
Beneficiary gender	Beneficiary gender code	
Beneficiary county	Beneficiary county	
Billing prov number	Billing provider ID number	
Billing prov name	Billing provider name	
Billing prov type	Billing provider type	
Billing prov spec	Billing provider specialty code	

Standard Field Name	Standard Field Description	Notes/Suggestions
Billing prov addr 1	Billing provider address first line. Note that the state may populate this data element with a contact name.	
Billing prov addr 2	Billing provider address second line	
Billing prov city	Billing provider city	
Billing prov state	Billing provider state	
Billing prov zip	Billing provider zip code	If possible do not include hyphens when using a ZIP+4 code
Billing prov phone	Billing provider phone number(s).	Phone extensions are acceptable, as are multiple phone numbers up to 50 bytes. e.g. ('1234567890 OR 0987654321') If possible, please do not use hyphens or parenthesis in this field
Billing prov fax	Billing provider fax number	If possible, please do not use hyphens or parenthesis in this field
Billing prov NPI	Billing provider NPI, when available	
Category of service	Classification for broad types of state/federal covered services.	
ICD9 proc code 1	ICD-9/10 surgical procedure code 1	
ICD9 proc code 2	ICD-9/10 surgical procedure code 2	
ICD9 proc code 3	ICD-9/10 surgical procedure code 3	
ICD9 proc code 4	ICD-9/10 surgical procedure code 4	
ICD9 proc code 5	ICD-9/10 surgical procedure code 5	
ICD9 proc code 6	ICD-9/10 surgical procedure code 6	

Standard Field Name	Standard Field Description	Notes/Suggestions
Diag 1	Diagnosis code 1 (primary)	
Diag 2	Diagnosis code 2	
Diag 3	Diagnosis code 3	
Diag 4	Diagnosis code 4	
Diag 5	Diagnosis code 5	
Diag 6	Diagnosis code 6	
Diag 7	Diagnosis code 7	
Diag 8	Diagnosis code 8	
Diag 9	Diagnosis code 9	
DRG	Diagnosis Related Group (DRG) code, if applicable	
Line item number	Line item number	If the claim does not have a line number associated with it, this can be left blank (note that this is a change to the previous instructions, which requested that states populate this with "0" for header level payments).
Sampled ind	Indicates if the individual line was sampled	Yes=Y and No=N. If two lines in a single claim were sampled, each line is marked with a Y in the claim. For header level sampling units, all lines are marked with a Y.
Proc code line	Procedure code on the line (HCPCS code or CPT) as it was adjudicated	
Units paid	Number of units (services) paid or drug quantity dispensed	

Standard Field Name	Standard Field Description	Notes/Suggestions
Amount 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
Proc mod 1	Procedure Code Modifier- 1 on the lines as it was adjudicated	
Proc mod 2	Procedure Code Modifier – 2 on the line as it was adjudicated	
Proc mod 3	Procedure Code Modifier – 3 on the line as it was adjudicated	
Proc mod 4	Procedure Code Modifier – 4 on the line as it was adjudicated	
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.	
Perf prov number	Performing (servicing) provider ID number	
Perf prov name	Performing (servicing) provider name	
Perf prov type	Performing (servicing) provider type	
Perf prov spec	Performing (servicing) provider specialty code	
Perf prov address 1	Performing (servicing) provider address first line. Note that the state may populate this data element with a contact name.	
Perf prov address 2	Performing (servicing) address second line	
Perf prov city	Performing (servicing) provider city	

Standard Field Name	Standard Field Description	Notes/Suggestions
Perf prov state	Performing (servicing) provider state	
Perf prov zip	Performing (servicing) provider zip code	If possible do not include hyphens when using a ZIP+4 code.
Perf prov phone	Performing (servicing) provider phone number	Phone extensions are acceptable, as are multiple phone numbers up to 50 bytes. (e.g. '1234567890 OR 0987654321') If possible, please do not use hyphens or parenthesis in this field
Perf prov fax	Performing (servicing) provider fax number	If possible, please do not use hyphens or parenthesis in this field
Perf prov NPI	Performing provider's NPI, when available	
DOS from line	From date of service on the line	
DOS to line	To date of service on the line	
POS	Place of service	
TOS	Type of service	
NDC code	National Drug Code (NDC)	Made up of labeler(mfr) + product+ pkg size configurations Must be 11 digits (do not cut off leading or ending zeros)
Drug order date	Date drug was prescribed for a pharmacy claim	
Prescription number	Prescription number for the pharmacy claim line	
Prior authorization	Prior authorization number on the header or line	Prior authorization number will be the same on all lines if PA only available at the claim level

Standard Field Name	Standard Field Description	Notes/Suggestions
Date paid line	For those Medicaid systems that have paid dates at the line level (because they adjudicated each line separately), the date paid for that line, if different from the date of payment for the entire claim.	
Record type	Denote if the record is a header or a line	H=header, L=line
User fields 1-5	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.	

SECTION 4: QUALITY REVIEW

Quality review saves time and resources for both the state and CMS contractors by identifying data problems early in the PERM process. Please perform a quality review of the sampled claim details data for your state each quarter prior to submitting files to the SC. Table 2 below lists suggested minimal quality control checks for states to complete.

Table 2: Minimum Sampled Claim Details Submission Quality Control Checks

Quality Review	Suggested Tests
1) Ensure all required fields are reported in the detail file	Prepare a list of all fields in the data submission and compare it to the list of fields in Table 1 (note that some fields only apply to certain claim or provider types) Identify any missing fields Determine why the field is missing; if the state does not report a field, let the SC know when submitting the file
2) Check that key fields are properly formatted	Check that key fields are not truncated or contain extra data. Review fields such as: - ICN/TCN - Line number - Billing provider number - Beneficiary ID - Paid amount - Claim type - Payment status - Sampled unit indicator - Date paid - Source location - POS - NDC
3) Check that the paid date for all records is for the appropriate quarter for FY 2011	Review the values in the paid date field
4) 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	Review file, making sure that it contains all lines associated with each claim (whether or not the claim was sampled at the header or the line level)

5) Review provider information	Verify that provider information, including addresses, phone numbers, and fax numbers, is complete and up-to-date

SECTION 5: DATA TRANSMISSION AND SECURITY

This section discusses the PERM data submission media, PERM data submission formats, transmission cover sheet and quality control verification, and data transmission and security.

1. **Submission media:** The SC's data systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, portable hard drives). It is preferred that states send their data via secure FTP (SFTP). 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.

2. **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.

3. **Transmission cover sheet:** Please submit a transmission cover sheet with every data submission. Examples of the Medicaid fee-for-service and Medicaid managed care data transmission cover sheet and quality control verification are provided in **Appendix A.** Please complete and submit a cover sheet with every PERM data submission. The state may burn 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.

4. **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.

5. **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:

1. Contact the SC to discuss the SFTP site, establish a SFTP connection, and test the SFTP prior to data submission
2. Encrypt and password-protect data files
3. Zip all PERM data files, including the Transmission Cover Sheet and file layouts, into a single zip file
4. SFTP the zipped file
5. Email a copy of the Transmission Cover Sheet and password(s) to the SC to indicate that the PERM data is available on the SFTP site

Follow these steps if mailing data:

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

Appendix A

Transmission Cover Sheet and Quality Control Verification
Medicaid Fee-For-Service

Complete and submit this cover sheet with every PERM data submission.

Contact Information	
State:	
Date:	
Quarter:	
Contact person for data questions:	
Name:	
Phone:	
Email:	
Title:	
Organization:	

Data Descriptions *Complete information below. Please include a row describing your data documentation. Add more rows as necessary.*

Data Description (e.g., Q1 Medicaid FFS details; 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)				

Control Totals *Add more tables as necessary.*			
Data filename	**Month**	**Total Lines**	**Total Dollars**
(add rows as necessary)			

Quality Control Verification - FFS *States are responsible for quality control checking each dataset prior to submitting the data to the SC. These are the minimum required checks. Please provide the name of the person "signing off" on each QC check.* ***By placing your name in this box, you are verifying that your state performed the quality control check and the results have been reviewed and are acceptable.***		
Quality Control Check	**Suggested Test**	**Name**
Ensure all required fields are reported in the detail file	Prepare a list of all fields in the data submission and compare it to the list of fields in Table 1 (note that some fields only apply to certain claim or provider types) Identify any missing fields Determine why the field is missing; if the state does not report a field, let the SC know when submitting the file	
Check that key fields are properly formatted	Check that key fields are not truncated or contain extra data. Review fields such as: - ICN/TCN - Line number - Billing provider number - Beneficiary ID - Paid amount - Claim type - Payment status - Sampled unit indicator - Date paid - Source location - POS - NDC	

Quality Control Verification - FFS *States are responsible for quality control checking each dataset prior to submitting the data to the SC. These are the minimum required checks. Please provide the name of the person "signing off" on each QC check.* ***By placing your name in this box, you are verifying that your state performed the quality control check and the results have been reviewed and are acceptable.***		
Quality Control Check	**Suggested Test**	**Name**
Check that the paid date for all records is for the appropriate quarter for FY 2011	Review the values in the paid date field	
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	Review file, making sure that it contains all lines associated with each claim (whether or not the claim was sampled at the header or the line level)	
Review provider information	Verify that provider information, including addresses, phone numbers, and fax numbers, is complete and up-to-date	

Identification of Potential Data Discrepancies or Other Information: *Please indicate whether there have been any major issues or problems with producing the Details that we should be aware of, including any changes that may have occurred since the last quarter. Also, please use this space to share other important information about your data submission.*