RY 2020 PERM Sampled Claim Details Data Submission Instructions

Medicaid Fee-For Service and CHIP Fee-For Service

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SECTION 1: Overview

Submitting details information for sampled Fee-For-Service (FFS) claims to the Statistical Contractor (SC) is the next critical step in the PERM process following universe submission. The Review Contractor (RC) uses the information states submit in the details data to request medical records and conduct medical record review on sampled FFS claims. It is vital that states submit accurate and complete details data in order for the RC to contact the correct provider and review the associated medical record appropriately and efficiently. Any delays in the provision of complete and accurate claims details data could result in subsequent delays in requesting medical records from providers.

Note: Details data are only required for FFS sampled claims. States are not required to submit details data for managed care samples.

These instructions are intended to guide state staff in the preparation of the claims data that they will have to provide to support the PERM SC and RC.

The instructions include:

- An overview of the details process;
- The PERM-specific definitions of fields required in the details;
- The specifications for required fields in terms of data types and formats;
- An overview of the Quality Control (QC) review process, including checks states can perform on the details data prior to submitting them to the SC;
- An overview of details data transmission and security;
- Tables of required details fields;
- A Transmission Cover Sheet for QC verification; and
- The Standard Details Crosswalk Template.

Each member of the state's PERM team, including technical and non-technical staff from both the state and any relevant vendors, should receive a copy of these instructions and review them early in the process.

The steps for the details submission process are as follows:

1) The SC selects random quarterly samples of payments from the FFS universes provided by each state and returns the sampled Medicaid and CHIP FFS claims to the state;
2) The SC conducts a "details intake call" (approximately one hour) with each state and the RC after returning the first FFS claims sample. Each member of the state's PERM team who will be involved in the collection of the details data, including any contractors or vendors, is encouraged to attend the details intake call. States should also include participants from any outside programs or agencies that have any claims in the sample.

The purpose of this call is to:

- Provide an overview of the details requirements;
- Collect additional information from each state to help with the SC review of the details submission. This includes identification of required fields that are not maintained in the state's data systems or fields that will not be submitted for certain claim types for valid reasons (e.g., the Diagnosis Related Group (DRG) field will not be populated for inpatient claims if these claims are not paid based on the DRG methodology). Knowing this information ahead of time helps the SC validate and format the details as necessary; and
- Provide states with an opportunity to ask questions about the required fields and the details process;

3) The state sends the SC a file with details for the sampled payments within two weeks of receiving the list of sampled claims;
4) The SC reviews the sampled claim details for accuracy and completeness, sends follow-up questions to the state if necessary and standardizes format of the details data according to the RC specifications; and
5) After all data and formatting issues are resolved, the SC sends the details file to the RC to request medical records. The details file is also sent to the ERC for their records.

SECTION 2: Sampled Claim Details Data

While the routine PERM universe submission requires a minimal number of variables, the details submission requires approximately 94 fields. The RC requires these fields to request medical records and conduct medical review (e.g., verify if services are rendered in accordance with state policy, confirm medical necessity of services, determine whether the services rendered match the service codes billed and paid). It is important that the details be accurate and complete.

States should be aware that even though individual line items are sampled for PERM, it is 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 the SC sampled a payment provided in the universe as a header level claim, the state must return in the details submission all lines associated with that claim, as well as the sampled claim header.
- If a claim is paid at the line level and the SC sampled, for example, line 2, the information returned by the state must include information from the header and all lines associated with that claim header, including line 2.

Please refer to the "sampling unit level" field with each sampled item to determine if a claim was sampled at the header or line level. Sampled items with an "H" were sampled at the header level and those with an "L" were sampled at the line level.

States may submit one file with claim headers and a second file with claim lines, or submit one file with both claim header and line data combined. The SC will work with each state to determine the most appropriate file structure.

Particular fields in the details request that are vital to the medical record review process are:

- **PERM ID:** Every sampled payment (i.e., FFS claim or managed care capitation payment) will have a PERM ID that are used by the RC, SC, and Eligibility Review Contractor (ERC) to track that payment. The SC creates this field for the purpose of assigning a unique identifier to each sampled claim. The PERM ID follows a standard logic:

  SS = state

  C/M = C for CHIP or M for Medicaid

  20 = year

  0# = quarter number (01, 02, 03 or 04)

  F/M = F for FFS or M for managed care

  XXX = three-digit sequential number

  Example: The 51st FFS payment sampling unit from the Alabama 2020 Q1 CHIP universe will have the following PERM ID: ALC2001F051

The SC sends samples back to the state in the same format as received from the state, and appends a unique PERM ID to each record. States are required to include the associated PERM ID for each sampled FFS claim in the details submission. States will also be able to use the PERM ID to track a sampled claim's progress on the State Medicaid Error Rate Finding (SMERF) System website;

- **ICN:** This is a unique claim identifier or internal control number assigned by the state for each claim or payment. Each record in the PERM universe must be able to be uniquely identified with data elements contained in the ICN; for "dummy" claims, states must ensure the ICN information can tie back to the payment in the state's systems. All of the sampled lines must have the same ICN in the sampler file and in the details file. Please notify the SC if there is PHI contained in any of your state ICN's. This information will be posted on the SMERF website.
- **Recipient ID, Name, Date of Birth, Gender, County, Eligibility Category, and Date of Death (if applicable):** Complete and accurate data for these recipient fields are critical for requesting medical records and conducting eligibility reviews. If states were unable to provide complete recipient information in the universe it **MUST** be provided in the details.
- **Billing Provider and Performing Provider:** Identifiers for both the billing provider and the performing provider (Name and ID) should be included, along with the providers' addresses and telephone numbers. Provider fax numbers and NPI should be provided when available. **Billing provider type and specialty are also important for**

header level claims since they help the RC to identify and request medical records from the correct provider for each claim.

In some cases, such as when the billing provider in the 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 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 and obtain the record that supports the claim.

Note: 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;

- **Dates of Service:** Dates of service (from/to) are necessary for both header and line level claims. There are four separate fields for capturing these data. These fields are called "dos_from_clm" and "dos_to_clm" for header claims and "dos_from_line" and "dos_to_line" for line claims.

  States are advised to inform the SC of any missing values for dates of service fields and provide the reason why they are missing. Dates of service for header level claims ("dos_from_clm" and "dos_to_clm" fields) should reflect the dates of service for all lines on the claim and not just the sampled line. Dates of service for line level claims ("dos_from_line" and "dos_to_line") should be populated even if they are the same as the dates of service for the header.

  In addition, it is important to ensure that the dates of service for each line of a claim ("dos_from_line" and "dos_to_line") fall within the dates of service range for the entire claim ("dos_from_clm" and "dos_to_clm"). States should inform SC if there are any variations from this rule for reporting dates of service during the details intake calls and on the Details Crosswalk Tables shown in Appendix B;

- **Units Paid:** Verifying the appropriate units of service paid is one of the essential components of the medical record review. Data for this field are particularly important for drug claims. All paid drug records in the details data must have valid units paid that are greater than zero. If the number of units paid for drug records are not available, states are advised to provide the quantity dispensed or other similar and relevant data. In addition, for data in the "units_paid" field that are not whole numbers and have fractional values (e.g., 3.5), it is important to ensure that the fractional value is valid and reflects the accurate number of units paid for the corresponding claim;
- **Total Computable Amount Paid:** This field should be populated for both header and line claims and should not include any third-party or patient liability paid amounts, such as copayments. Total Computable Amount is equal to the Federal Share plus State Share plus Any local share. The amount paid should be net of all recipient and third party cost sharing (co-payments, TPL, coinsurance, etc.) The values for this field should also match the paid amount submitted in the universe for header or line claims;

- **Provider Fields:**
    - Billing Provider – These fields should be populated with information about the provider who submitted the services for reimbursement.
    - Performing Provider – This is the provider who performed or provided the service to the recipient. If the claim is an institutional claim, the performing provider fields should be populated with the attending provider.
    - Attending Provider – For institutional claims, this should be the physician who attends a hospital at stated times to visit the patients and give directions as to their treatment. It should be an individual and not an institution.
    - Prescribing Provider – This should be the physician who prescribed the medication or supply for the recipient.
    - Referring Provider – This field has different meanings for different types of claims. This information needs to be provided when the billing entity is not the physician who ordered or prescribed the service. Please read the below list carefully:
        - Referring provider – For claims for lab, x-rays, physical/occupations/speech therapy, durable medical equipment, prosthetics and orthotics, and certain other outpatient and clinic services
- **Claim Type:** This field is the state claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim. The values for this field in the details file should generally match to the values in the claim type field in the sampler file. However, a state data dictionary is required at the time of details submission if there are differences in claim type values between the sampler and details files;
- **NDC Code:** Mandatory 11-digit number for all pharmacy claims;
- **Medical Record Contact Name, Address, and Phone Number:** For any medical records requests that need to be directed to someone other than the Billing or Performing Providers, please include this contact information in the Medical Records fields. This is seen most often with chain pharmacies, institutions, physicians with multiple practice locations, waiver claims, or caregiver services. In many of these instances, medical records requests are more successful if they are directed to a location that frequently handles these types of requests and has access to the required records; and
- **Fields with Pre-defined Standard Data Values:** The following fields have pre-established definitions and cannot have any missing values in the details file. The values in the below fields should match what was submitted as part of the universe data. A state data dictionary is required for values that deviate from the standard definitions for each field shown below:
    - **Recipient Gender:** "M" for Male and "F" for Female
    - **Payment Status:** "P" for Paid and "D" for Denied

  This field is the paid or denied indicator for each claim or claim line as it was originally adjudicated; should not reflect an adjusted payment status.

- **Medicare Crossover Indicator:** "Y" for Yes and "N" for No

Indicates whether the claim is a Medicare crossover claim.

- **Sampling Unit Level:** "H" for Header and "L" for Line

This field is a code that is used to denote if the record is a header or a line claim.

Note: States are required to submit this field only if they choose to submit a single file for header and line claims combined.

- **Standard Field Names**: If states choose not to use these field names or provide the data in a different order, states are required to include a crosswalk between the state field names and the standard details field names in the Details Transmission Cover Sheet. States must also include data dictionaries or crosswalks with file layouts and decodes for each field, as applicable.

Section 4 of these instructions and the Quality Review component of the details data fields and descriptions (Appendix A) also include specific suggestions for minimum checks that states should run on the details submission to ensure that the data are accurate and complete.

SECTION 3: Changes to the Reporting Year (RY) 2020 PERM Details Data Submission Instructions from FY 2016

There have been ten updates to the required fields since the FY 2016 cycle. If any of the eligibility fields listed below were provided in the fee for service universe then the state would not need to resubmit them in the details.

General Fields	
Federal Claims Category (if not provided in the universe data)	This column should be populated with MSIS Code, CMS 64 line, or other state mapping into a federal claim category. The values help reconcile between the PERM universe and the reported federal dollars on the CMS 64/21 forms. States may also use this field in their quality review to determine all federally matched Title 19 and 21 payments are included in PERM submission.
Eligibility Fields	
Recipient Eligibility Category	This field has been added to note the specific reason the recipient qualifies to receive the service on the claim. This value should be the eligibility category used in adjudication of the payment.
Recipient Date of Death	This field should contain the date of death of the recipient if deceased. This field may be blank for the majority of recipients. This value should come from the adjudication system.
Provider Fields	
Attending Provider	For institutional claims, this should be the physician who attends a hospital at stated times to visit the patients and give directions as to their treatment. It should be an individual and not an institution.
Prescribing Provider	This should be the physician who prescribed the medication or supply for the recipient.
Billed Fields	
Billed Units	This field should only be used if the units of service billed by the provider are different than the units of service that are included in the current 'Units of Service" field. This information is used by the RC during the medical record reviews. If your state does not capture this information the new field may be left blank.
Bill Type	This field should be used to distinguish which claims are billed on the UB-04 form or the CMS 1500. If the claim was not billed on either form, the value may be blank or populated with a state-specific value. If state-specific values are given, please provide a data dictionary decode. This information is used by the RC during the medical record reviews. If your state does not capture this information, the new field may be left blank.
Billed Procedure Code	This field should be used only if the procedure code on the line billed is different than the procedure code provided in the 'Proc Code Line' field. If the billed procedure code is the same as the one listed in the 'Proc Code Line' field, 'Billed Procedure Code' may be left blank. If state-specific procedure codes are used in this field, please provide data dictionary decodes. If your state does not maintain this field, the column may also be left blank.

General Fields	
Billed Revenue Code	This field should be used only if the revenue code on the line billed is different than the revenue code provide in the 'Rev Code' field. If the billed revenue code is the same as the paid, then the 'Billed Rev Code' may be left blank. If state-specific revenue codes are used in these fields, please provide data dictionary decodes. If your state does not maintain this field, the column may also be left blank.
Billed Amount	This column should only be populated if the billed dollar amount is different than the total computable paid amount on the claim. If the billed amount equals the paid amount, the 'Billed Amt' field may be left blank. If your state does not maintain this field, the column may also be left blank.

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 details process. States should perform a quality review of the sampled claim details data prior to submitting files to the SC. Table 2 lists suggested minimal QC checks for states to complete.

Table 1: Minimum Sampled Claim Details Submission QC Checks

Quality Review	Suggested Tests
1) Ensure all required fields are reported in the details file.	▪ Prepare a list of all fields in the data submission and compare it to the list of fields in Appendix A (note that some fields only apply to certain claim or provider types). ▪ Identify any missing fields or fields which may have missing values for certain records in the data. ▪ Determine why the field or certain values in the field are missing; if the state does not maintain a field in its entirety or for certain claim types in the state's data system, provide an explanation accordingly on the Details Transmission Cover Sheet in Appendix C for the impacted fields.

Quality Review	Suggested Tests
2) Ensure all required documentation for decoding, formatting, and validating the data are included with each details submission.	▪ When using field names other than standard field names in Table 1, provide information for mapping your state's field names to the standard details field names. ▪ Indicate which data fields require a data dictionary. Provide decodes for each field (as applicable) as well as any necessary file layouts. ▪ Provide an updated data dictionary, if definitions for certain fields in the details have changed from definitions provided at the time of universe submission. ▪ Use the "Standard Details Crosswalk Template" in Appendix B to enter the required information for each field.
3) Check that 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 the 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).
4) Check for consistency of data between Universe and Details.	▪ Review the fields in the details for which data have also been submitted in the universe. ▪ Ensure there is no discrepancy between values reported in the universe and details. If values in a specific field in the details have changed from their values in the universe for valid reasons, provide an explanation on the transmission cover sheet in Appendix B. ▪ This is particularly important for the following fields: ○ Total paid amount: values for this field should also match the paid amount submitted in the universe for header or sum of all amount paid line for line level claims; ○ Claim Type: The values for this field in the details file should generally match to the values in the claim type field in the sampler file; ○ ICN; ○ Dates of service; ○ Date paid; ○ Line number; ○ Sampling unit level; ○ Medicare crossover; ○ Provider type; and ○ Source location.

Quality Review	Suggested Tests
5) Check that key fields are properly formatted and have valid values according to the guidelines for Quality Review in Appendix A: Required Fields for Details Submission. *Please ensure that no fields are populated with dummy values. Those will have to be removed before the file is sent to the RC.*	▪ Problems with these fields including missing values without explanation will result in automatic rejection of the details file: o PERM ID; o ICN/TCN; o Line number; o Billing provider number; o Billing provider name; o Recipient ID; o Recipient name; o Recipient gender; o Recipient date of birth; o Recipient eligibility category; o Recipient effective date; o Recipient status; o Paid amount; o Claim type; o Payment status; o Units Paid (where units paid are not available for pharmacy claims, please include the quantity dispensed); o Date of Service (header and line); o NDC; o Sampling Unit Level (is needed only when submitting a single file for header and line claims combined); o Medicare crossover indicator; and o ICD indicator when ICD/diagnosis codes are present on the claim.
6) Review provider information.	▪ Verify that provider information, including addresses, phone numbers, and fax numbers, is complete and up-to-date. Verify that only valid mailing addresses are provided in address 1 and address 2 fields. ▪ Ensure that institutional claims have attending provider information populated in the performing provider fields. Additionally, all pharmacy claims must have prescribing provider information provided.

Quality Review	Suggested Tests
7) If the contact name for medical record review is different from the billing or performing provider, please report this information in Medical Record Contact fields and not on the provider address fields.	▪ Populate medical record contact fields only when these contacts are different from contact data for billing, performing, and referring providers.
8) Review dates of service for the claim and for each claim line for accuracy and validity.	▪ Verify that the dates of service for each line of a claim ("dos_from_line" and "dos_to_line") are within the dates of service range for the entire claim ("dos_from_clm" and "dos_to_clm"). If there are any variation from this rule for reporting dates of service in your state, inform SC of this variation during the details intake calls and on the Details Crosswalk Tables shown in Appendix B.
9) Review units paid for all claims, especially for pharmacy claims.	▪ Ensure all claims have valid values in the units paid field. If there are fractional values in the units paid field (e.g., 3.5), verify these values are valid. ▪ Ensure pharmacy claims have non-missing values for units paid that are greater than zero. If the number of units paid for drug records are not available, provide the quantity dispensed or other similar and relevant data.

Quality Review	Suggested Tests
10) Additional Review.	▪ There are some fields that the RC expects to see populated for certain claims types. Please review the list below and ensure that either the information is provided in the details or that an explanation as to why it is not is included in the crosswalk returned to the SC. ▪ Outpatient claims – If a Revenue Code is provided, there should also be a value in at least one of the Procedure Code fields. Revenue Codes are generally not specific enough for the reviews performed by the RC. If groupers are used to pay these claims that code should be included in your submission. ▪ Long Term Care claims – These claims should have the Revenue code field populated. If paid by Level of Care or some other method, please note that in the crosswalk returned to the SC. ▪ Inpatient claims – Inpatient claims paid based upon a DRG should include both a DRG and Revenue Code. ▪ Pharmacy claims- These claims should have the NDC, Drug Order Date, Prescription Number, Units of Service, prescribing provider NPI, and prescribing provider name fields populated. Chain pharmacy provider address fields should include the store number. ▪ Diagnosis Code fields - These fields should be populated for all lines, with possible exceptions for dental and pharmacy claim lines. ▪ Local Codes – Decodes should be provided for any claims billed using local procedure, revenue, or diagnosis codes.

SECTION 5: Data Transmission and Security

This section discusses the PERM data submission media, PERM data submission formats, transmission cover sheet and QC 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, states 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 delimited (pipe, tab, etc.) 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 FFS details data submission. The format for the FFS details data Transmission Cover Sheet and QC verification are provided in Appendix C. 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, and FISMA requirements 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 recipient 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 an 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;

- Note: For very large files, more than one zip file may be necessary. Additionally, states with very large files may use third-party software to transmit data. Contact the SC for more information.

4) Upload the zipped file to the SFTP; and
5) Email the 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; and
7) E-mail the Transmission Cover Sheet and password(s) for the data to the SC.

Appendix A: Required Fields for Details Submissions

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
1	PERM ID	perm_id	Populated field will be provided to the state by the SC in the sampled claim file.	varchar	Copy the PERM ID for the sampled claim from the sampler file into the claim details extract.
2	ICN	clm_id_icn	Unique claim identifier (e.g., ICN, TCN, other state issued number).	varchar	Ensure all of the sampled lines have the same ICN in the sampler and in the details files. Ensure the field is not truncated and does not contain extra data. Each record in the Claims File must be able to be uniquely identified with data elements contained in the record, typically a combination of ICN and Line Number. 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.
3	Claim type	clm_type	State claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim.	varchar	Provide a data dictionary if a dictionary was not provided with universe data or if there are differences in claim type values between the universe and the details.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
4	Date Paid	date_of_payment	The date a claim or payment was originally 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.	varchar (mm/dd/yyyy)	Check that the paid date is a valid date and matches the original paid date submitted in the universe for all records.
5	Medicare crossover indicator	mcare_xover_ind	Indicates whether the claim is a crossover claim from Medicare to Medicaid; "Y" for yes , "N" for no.	varchar	Ensure all values are coded as "Y" or "N" and the field is populated for all records.
6	Category of service	service_category	Classification for broad types of state/federal covered services. Can be MSIS category of service or state-defined service type.	Varchar	Provide a data dictionary if a dictionary was not provided with universe data or if there are differences in service category values between the universe and the details.
7	Source location	source_location	The system of origin/location in which the claim was originally adjudicated. The system of origin/location in which the sampled unit was adjudicated.	varchar	Provide a data dictionary if a dictionary was not provided with universe data. Ensure values match values in the universe submission.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
8	Payment status	payment_status	Paid or denied indicator for each claim or claim line as it was originally adjudicated; should not reflect an adjusted payment status; "P" for paid, "D" for denied.	varchar	Ensure all values are coded as "P" or "D" and the field is populated for all records.
9	Total computable amount paid on the header	amt_paid_clm	Total computable amount for the claim (at the header). Total Computable Amount = Federal Share + State Share + Any local share. Amount paid should be net of all recipient and third party cost sharing (co-payments, TPL, coinsurance, etc.).	numeric (with decimals)	Ensure values in this field match the paid amount submitted in the universe for header claims. Ensure the field is not truncated or rounded, and does not contain extra data.
10	Date-of-service from (claim)	dos_from_clm	Beginning date of service on the claim.	varchar (mm/dd/yyyy)	Ensure beginning date of service is a valid date, is populated for all records and is prior to the ending date of service for the claim.
11	Date-of-service to (claim)	dos_to_clm	End date of service on the claim.	varchar (mm/dd/yyyy)	Ensure ending date of service is a valid date, is populated for all records and is after the beginning date of service for the claim.
12	Recipient ID	recipient_id	Recipient ID number; can be Medicaid ID or system-specific ID.	varchar	Ensure recipient ID is populated for all records.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
13	Recipient Name	recipient_name	Recipient Name; states may submit recipient name according to state preference (e.g., can submit multiple fields for first, middle, and last name or a single field containing recipient full name).	varchar	Ensure recipient name is populated for all records. Ensure the field is not truncated and does not contain extra data.
14	Recipient date of birth	recipient_dob	Recipient date of birth.	varchar (mm/dd/yyyy)	Ensure date of birth is a valid date and is populated for all records.
15	Recipient gender	recipient_gender	Recipient gender code; "M" for male, "F" for female.	varchar	Ensure all values are coded as "M" or "F" and the field is populated for all records.
16	Recipient county	recipient_county	Recipient county.	varchar	Provide a data dictionary.
17	Billing provider number	billing_prov_id	Billing provider ID number; can be NPI or legacy provider ID.	varchar	Ensure billing provider number is populated for all records.
18	Billing provider name	billing_prov_name	Billing provider name	varchar	Ensure the field is not truncated, does not contain extra data and is populated for all records.
19	Billing provider type	billing_prov_type	Billing provider type	varchar	Provide a data dictionary if a dictionary was not provided with universe data.
20	Billing provider specialty	billing_prov_spec	Billing provider specialty code	varchar	Provide a data dictionary if a dictionary was not provided with universe data.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
21	Billing provider address 1	billing_prov_address_1	Billing provider address first line If medical record contacts are different from the billing provider, please include this information in a separate user field.	varchar	Ensure that provider addresses are complete, up-to-date, and do not contain a medical record contact name instead.
22	Billing provider address 2	billing_prov_address_2	Billing provider address second line	varchar	
23	Billing provider city	billing_prov_city	Billing provider city	varchar	
24	Billing provider state	billing_prov_state	Billing provider state	varchar	Use the abbreviated 2-letter code for each state (e.g. WA for Washington state).
25	Billing provider zip	billing_prov_zip_code	Billing 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.
26	Billing provider phone	billing_prov_phone	Billing provider phone number(s) All phone numbers should be 10 digits, including the area code. Multiple phone numbers and phone extensions should be reported in separate user fields.	varchar	If possible, do not use hyphens or parentheses. Verify that the provider phone number is a complete and up-to-date 10 digit code. Include multiple phone numbers in separate user fields.
27	Billing provider fax	billing_prov_fax	Billing provider fax number, when available	varchar	If possible, do not use hyphens or parentheses. Verify that the provider fax number is a complete and up-to-date 10 digit code.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
28	Billing provider NPI	billing_prov_npi	Billing provider NPI, when available	varchar	
29	ICD procedure code 1	icd_proc_code_1	ICD-9/10 surgical procedure code 1	varchar	
30	ICD procedure code 2	icd_proc_code_2	ICD-9/10 surgical procedure code 2	varchar	
31	ICD procedure code 3	icd_proc_code_3	ICD-9/10 surgical procedure code 3	varchar	
32	ICD procedure code 4	icd_proc_code_4	ICD-9/10 surgical procedure code 4	varchar	
33	ICD procedure code 5	icd_proc_code_5	ICD-9/10 surgical procedure code 5	varchar	
34	ICD procedure code 6	icd_proc_code_6	ICD-9/10 surgical procedure code 6	varchar	
35	Diagnosis 1	diag_code_1	Diagnosis code 1 (primary)	varchar	
36	Diagnosis 2	diag_code_2	Diagnosis code 2	varchar	
37	Diagnosis 3	diag_code_3	Diagnosis code 3	varchar	
38	Diagnosis 4	diag_code_4	Diagnosis code 4	varchar	
39	Diagnosis 5	diag_code_5	Diagnosis code 5	varchar	
40	Diagnosis 6	diag_code_6	Diagnosis code 6	varchar	
41	Diagnosis 7	diag_code_7	Diagnosis code 7	varchar	
42	Diagnosis 8	diag_code_8	Diagnosis code 8	varchar	
43	Diagnosis 9	diag_code_9	Diagnosis code 9	varchar	
44	DRG	drg_code	DRG code, if applicable	varchar	
45	Line item number	clm_id_line_item_num	Number denoting individual claim detail/line item	numeric (no decimals)	

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
46	Procedure code line	proc_code_line	Procedure code on the line (HCPCS, CPT, or proprietary code) as it was adjudicated. If proprietary codes are used, State must indicate as such and provide necessary decode information.	varchar	
47	Units paid	units_of_svc_paid	Number of units (services) paid	numeric	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. Ensure that all paid drug records have valid units paid that are greater than 0. If the number of units paid for drug records are not available, please include quantity dispensed or other relevant information.
48	Total computable amount paid line	amt_paid_line	Total computable amount paid at the claim line. Total Computable Amount= Federal Share + State Share + Any Local Share. Amount paid should be net of any co-payments, third-party, or other recipient liability.	numeric (with decimals)	Ensure the field is not truncated, rounded and does not contain extra data.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
49	Procedure modifier 1	proc_mod_1	Procedure Code Modifier- 1 on the lines as it was adjudicated	varchar	
50	Procedure modifier 2	proc_mod_2	Procedure Code Modifier - 2 on the line as it was adjudicated	varchar	
51	Procedure modifier 3	proc_mod_3	Procedure Code Modifier - 3 on the line as it was adjudicated	varchar	
52	Procedure modifier 4	proc_mod_4	Procedure Code Modifier - 4 on the line as it was adjudicated	varchar	
53	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.	varchar	
54	Performing provider number	perf_prov_id	Performing (servicing/rendering) provider ID number Can be NPI or legacy provider ID	varchar	Ensure this field is populated for records billed at the claim line level.
55	Performing provider name	perf_prov_name	Performing (servicing) provider name	varchar	Ensure this field is populated for records billed at the claim line level.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
56	Performing provider type	perf_prov_type	Performing (servicing) provider type	varchar	Ensure this field is populated for records billed at the claim line level. Provide a data dictionary if a dictionary was not provided with universe data.
57	Performing provider spec	perf_prov_spec	Performing (servicing) provider specialty code	varchar	Ensure this field is populated for records billed at the claim line level. Provide a data dictionary if a dictionary was not provided with universe data.
58	Performing provider address 1	perf_prov_addr_1	Performing (servicing) provider address first line If medical record contacts are different from the performing provider, please include this information in a separate user field.	varchar	Ensure this field is populated for records billed at the claim line level. Verify that provider addresses are complete, up-to-date and do not include a medical record contact names instead.
59	Performing provider address 2	perf_prov_addr_2	Performing (servicing) address second line	varchar	Ensure this field is populated for records billed at the claim line level.
60	Performing provider city	perf_prov_city	Performing (servicing) provider city	varchar	Ensure this field is populated for records billed at the claim line level.
61	Performing provider state	perf_prov_state	Performing (servicing) provider state	varchar	Ensure this field is populated for records billed at the claim line level. Please use the abbreviated 2-letter code for each state (e.g. WA for Washington state).

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
62	Performing provider zip	perf_prov_zip_code	Performing (servicing) provider zip code Should contain either 5 or 9 digits (ZIP + 4 digit code)	varchar	Ensure this field is populated for records billed at the claim line level. If possible do not include hyphens when using a ZIP+4 digit code.
63	Performing provider phone	perf_prov_phone	Performing (servicing) provider phone number All phone numbers should be 10 digits, including the area code. Multiple phone numbers and phone extensions should be reported in separate user fields.	varchar	Ensure this field is populated for records billed at the claim line level. If possible, do not use hyphens or parentheses. Verify that the provider phone number is a complete and up-to-date 10 digit code. Include multiple phone numbers in separate user fields.
64	Performing provider fax	perf_prov_fax	Performing (servicing) provider fax number	varchar	Ensure this field is populated for records billed at the claim line level, when available. If possible, do not use hyphens or parenthesis in this field. Verify that the provider fax number is a complete and up-to-date 10 digit code.
65	Performing provider NPI	perf_prov_npi	Performing provider's NPI, when available	varchar	Ensure this field is populated for records billed at the claim line level, when available.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
66	Attending provider number	attend_prov_id	For institutional claims only, the specific individual provider ID number Can be NPI or legacy provider ID	varchar	Ensure this field is populated for institutional records.
67	Attending provider name	attend_prov_name	For institutional claims only, the specific individual attending provider name	varchar	Ensure this field is populated for institutional records.
68	Attending provider type	attend_prov_type	For institutional claims only, the specific individual attending provider type	varchar	Ensure this field is populated for institutional records. Provide a data dictionary if a dictionary was not provided with universe data.
69	Attending provider spec	attend_prov_spec	For institutional claims only, the specific individual attending provider specialty code	varchar	Ensure this field is populated for institutional records. Provide a data dictionary if a dictionary was not provided with universe data.
70	Attending provider address 1	attend_prov_addr_1	For institutional claims only, the specific individual attending provider address first line If medical record contacts are different from the Attending provider, please include this information in a separate user field.	varchar	Ensure this field is populated for institutional records. Verify that provider addresses are complete, up-to-date and do not include a medical record contact names instead.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
71	Attending provider address 2	attend_prov_addr_2	For institutional claims only, the specific individual attending address second line	varchar	Ensure this field is populated for institutional records.
72	Attending provider city	attend_prov_city	For institutional claims only, the specific individual attending provider city	varchar	Ensure this field is populated for institutional records.
73	Attending provider state	attend_prov_state	For institutional claims only, the specific individual attending provider state	varchar	Ensure this field is populated for institutional records. Please use the abbreviated 2-letter code for each state (e.g. WA for Washington state).
74	Attending provider zip	attend_prov_zip_code	For institutional claims only, the specific individual attending provider zip code Should contain either 5 or 9 digits (ZIP+4 digit code)	varchar	Ensure this field is populated for institutional records. If possible do not include hyphens when using a ZIP+4 digit code.
75	Attending provider phone	attend_prov_phone	For institutional claims only, the specific individual attending provider phone number All phone numbers should be 10 digits, including the area code. Multiple phone numbers and phone extensions should be reported in separate user fields.	varchar	Ensure this field is populated for institutional records. If possible, do not use hyphens or parentheses. Verify that the provider phone number is a complete and up-to-date 10 digit code. Include multiple phone numbers in separate user fields.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
76	Attending provider fax	attend_prov_fax	For institutional claims only, the specific individual attending provider fax number	varchar	Ensure this field is populated for institutional records. If possible, do not use hyphens or parenthesis in this field. Verify that the provider fax number is a complete and up-to-date 10 digit code.
77	Attending provider NPI	attend_prov_npi	For institutional claims only, the specific individual attending provider's NPI, when available	varchar	Ensure this field is populated for institutional records.
78	Prescribing provider name	prescribe_prov_name	Prescribing provider name	varchar	For Pharmacy claims, this will be the prescribing provider name.
79	Prescribing provider NPI	prescribe_prov_npi	Prescribing provider NPI	varchar	For Pharmacy claims, this will be the prescribing provider NPI.
80	Referring Prov Name	ref_prov_name	Referring provider name	varchar	Ensure this field is populated for records billed at the claim line and header level, when available. Most common types of claims with this information are: lab/imaging, durable medical equipment (DME), and prosthetics/orthotics

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
81	Referring Prov NPI	ref_prov_npi	Referring provider NPI	varchar	Ensure this field is populated for records billed at the claim line and header level, when available. Most common types of claims with this information are: lab/imaging, durable medical equipment (DME), and prosthetics/orthotics
82	Medical Record Contact Name	mr_contact_name	Medical record contact name	varchar	Ensure this field is populated for records billed at the claim line and header level, when available. Do not duplicate this field if values are the same as data in the corresponding fields for billing, performing or referring providers.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
83	Medical Record Contact Add 1	mr_contact_addr_1	Medical record contact address first line.	varchar	Ensure this field is populated for records billed at the claim line and header level, when available. Do not duplicate this field if values are the same as data in the corresponding fields for billing, performing or referring providers.
84	Medical Record Contact Addr 2	mr_contact_addr_2	Medical record contact address second line	varchar	Ensure this field is populated for records billed at the claim line and header level, when available. Do not duplicate this field if values are the same as data in the corresponding fields for billing, performing or referring providers.
85	Medical Record Contact City	mr_contact_city	Medical record contact city	varchar	Ensure this field is populated for records billed at the claim line and header level, when available.
86	Medical Record Contact State	mr_contact_state	Medical record contact state: 2-char postal abbreviation.	varchar	Ensure this field is populated for records billed at the claim line and header level, when available. Do not duplicate this field if values are the same as data in the corresponding fields for billing, performing or referring providers.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
87	Medical Record Contact Zip	mr_contact_zip_code	Medical record contact zip code. Should contain either 5 or 9 digits (ZIP+4 digit code).	varchar	Ensure this field is populated for records billed at the claim line and header level, when available. If possible do not include hyphens when using a ZIP+4 digit code. Do not duplicate this field if values are the same as data in the corresponding fields for billing, performing or referring providers.
88	Medical Record Contact Phone	mr_contact_phone	Medical record contact phone number. All phone numbers should be 10 digits, including the area code. Multiple phone numbers and phone extensions should be reported in separate user fields.	varchar	Ensure this field is populated for records billed at the claim line and header level, when available. Do not duplicate this field if values are the same as data in the corresponding fields for billing, performing or referring providers.
89	Date-of-service from (line)	dos_from_line	Beginning date of service on the line. Should be included for each line of a claim.	varchar (mm/dd/yyyy)	Ensure beginning date of service is a valid dates, is populated for all line level claims and is prior to the ending date of service for the line claims.
90	Date-of-service to (line)	dos_to_line	End date of service on the line. Should be included for each line of a claim.	varchar (mm/dd/yyyy)	Ensure ending data of service is a valid date, is populated for all line level claims and is after the beginning date of service for line claims.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
91	Place of service	place_of_svc	Place of service	varchar	Provide a data dictionary if a dictionary was not provided with universe data.
92	Type of service	type_of_svc	Type of service	varchar	Provide a data dictionary if a dictionary was not provided with universe data.
93	National Drug Code (NDC)	ndc_code	Made up of labeler (mfr) + product + pkg size configurations	varchar	Ensure NDC codes are 11 digits including leading and trailing zeroes. Ensure this field is populated for all pharmacy claims.
94	Drug order date	drug_order_dt	Date drug was prescribed for a pharmacy claim	varchar (mm/dd/yyyy)	Ensure this field is populated for all pharmacy claims.
95	Prescription number	rx_num	Prescription number for the pharmacy claim line	varchar	Ensure this field is populated for all pharmacy claims.
96	Prior authorization number (header or line)	prior_auth_num	Prior authorization number will be the same on all lines if PA only available at the claim level.	varchar	
97	Date paid line	date_of_payment_line	Paid date for claim Line	varchar (mm/dd/yyyy)	Ensure this field is populated for records billed at the claim line level.
98	Sampling unit level	sampling_unit_level	A code that is used to denote if the record is a header or a line claim "H"= header, "L"= line	varchar	Ensure all values are coded as "H" or "L" and the field is populated for all records.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
99	ICD Version	icd_version	Indicates if the submitted diagnosis codes are ICD-9 or ICD-10 versions.	numeric	If the state will be submitting details with a mix of ICD-9 and ICD-10 codes, populate field with a value of either "9" or "10" to indicate the version number. If all diagnosis codes are the same version, states are not required to populate this field but should notify Lewin which ICD version is being used.
100	Billed Units	billed_units	Indicates the number of units billed if that number differs from what was reported in the Units Paid field.	numeric	If billed units are different from paid units, populate this field. Otherwise, leave blank.
101	Bill Type	bill_type	A three-digit numeric code which identifies the specific type of bill (inpatient, outpatient, adjustments, voids, etc.). The first digit represents Type of Facility, the second digit the Bill Classification, and the third digit the Frequency, which for SPARCS purposes is the transaction type. This field may also be 4 digits, starting with a preceding zero.	varchar	Required for institutional claims

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
102	Billed Procedure Code	billed_proc_code	Billed procedure code on the line (HCPCS, CPT, or proprietary code), if different than the paid procedure code. If proprietary codes are used, State must indicate as such and provide necessary decode information. Changes in procedure code from billed to paid may occur automatically in certain state systems. If a certain code is billed, the system automatically changes it to another code (e.g., updated correct code or state proprietary code) to pay.	varchar	Populate if different than procedure code line on adjudicated version of claim. Please provide decodes in data dictionary if proprietary codes are used.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
103	Billed Revenue Code	billed_rev_code	Billed revenue code for the claim line. This field should be populated if different from the paid revenue code. Changes in revenue code from billed to paid may occur automatically in certain state systems. If a certain code is billed, the system automatically changes it to another code (e.g., updated correct code or state proprietary code) to pay. Note that ALL revenue codes should be submitted for a claim. A separate record should be created for each revenue code.	varchar	Populate if different from revenue code on adjudicated version of claim. Please provide decodes in data dictionary if proprietary codes are used.
104	Billed Amount	billed_amt	Original billed amount on claim from provider. This amount should be net of all recipient and third party cost sharing (co-payments, TPL, coinsurance, etc.) recipient.	numeric	Populate if different from adjudicated paid amount on claim.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
105	Federal Claim Category	federal_claim_category	MSIS Code, CMS 64 line, or other state mapping into a federal claim category	varchar	Please provide decodes in data dictionary if proprietary codes are used.
106	Recipient Eligibility Category	recipient_elig_cat	The specific benefit the recipient qualifies for that is used in adjudication of payment of the claim and should come from the adjudication system.	varchar	Provide a data dictionary.
107	Recipient Date of Death	recipient_death_date	Date of death of recipient	varchar	Note in documentation if filler values (e.g., future dates) are used to indicate no date of death.
108	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.		If necessary, provide a data dictionary for the data in the user fields.
109	User field 2		Same as above.		Same as above.
110	User field 3		Same as above.		Same as above.
111	User field 4		Same as above.		Same as above.
112	User field 5		Same as above.		Same as above.
113	User field 6		Same as above.		Same as above.
114	User field 7		Same as above.		Same as above.

Field Number	Field Designation	Standard Field Name	Field Description	Standard Field Format	Data Dictionary Requirements & Suggested Quality Review
115	User field 8		Same as above.		Same as above.
116	User field 9		Same as above.		Same as above.
117	User field 10		Same as above.		Same as above.

Appendix B: Standard Details Crosswalk Template

Please match your state's field names to the standard details field names below, and also indicate which data dictionary or crosswalk includes the layouts and decodes for each field (as applicable). If certain fields will not be populated by your system (e.g., if you do not pay any inpatient claims on a DRG or include fax numbers in your provider data), please note that as well.

Quality Review- States are responsible for QC checking of each dataset prior to submitting the data to the SC. By placing your name in this box, you are verifying that your state performed the suggested QC checks for each field and the results have been reviewed and are acceptable.	Name

Standard Details Field Name	State Details Field Name *(if different form Standard Field Name)*	Filename Containing Data Layouts and Decodes	Explanation for Missing Data or Additional Information *(if any)*
perm_id		**N/A**	
clm_id_icn			
clm_type			
date_of_payment			
mcare_xover_ind			
service_category			
source_location			
payment_status			
amt_paid_clm			
dos_from_clm			
dos_to_clm			
recipient_id			
recipient_name			
recipient_dob			
recipient_gender			

Standard Details Field Name	State Details Field Name *(if different form Standard Field Name)*	Filename Containing Data Layouts and Decodes	Explanation for Missing Data or Additional Information *(if any)*
recipient_county			
billing_prov_id			
billing_prov_name			
billing_prov_type			
billing_prov_spec			
billing_prov_address_1			
billing_prov_address_2			
billing_prov_city			
billing_prov_state			
billing_prov_zip_code			
billing_prov_phone			
billing_prov_fax			
billing_prov_npi			
icd_proc_code_1			
icd_proc_code_2			
icd_proc_code_3			
icd_proc_code_4			
icd_proc_code_5			
icd_proc_code_6			
diag_code_1			
diag_code_2			
diag_code_3			
diag_code_4			
diag_code_5			
diag_code_6			

Standard Details Field Name	State Details Field Name *(if different form Standard Field Name)*	Filename Containing Data Layouts and Decodes	Explanation for Missing Data or Additional Information *(if any)*
diag_code_7			
diag_code_8			
diag_code_9			
drg_code			
clm_id_line_item_num			
proc_code_line			
units_of_svc_paid			
amt_paid_line			
proc_mod_1			
proc_mod_2			
proc_mod_3			
proc_mod_4			
rev_code			
perf_prov_id			
perf_prov_name			
perf_prov_type			
perf_prov_spec			
perf_prov_addr_1			
perf_prov_addr_2			
perf_prov_city			
perf_prov_state			
perf_prov_zip_code			
perf_prov_phone			
perf_prov_fax			
perf_prov_npi			

Standard Details Field Name	State Details Field Name *(if different form Standard Field Name)*	Filename Containing Data Layouts and Decodes	Explanation for Missing Data or Additional Information *(if any)*
attend_prov_id			
attend_prov_name			
attend_prov_type			
attend_prov_spec			
attend_prov_addr_1			
attend_prov_addr_2			
attend_prov_city			
attend_prov_state			
attend_prov_zip_code			
attend_prov_phone			
attend_prov_fax			
attend_prov_npi			
prescribe_prov_name			
prescribe_prov_npi			
referring_prov_name			
referring_prov_npi			
medical_record_contact_name			
medical_record_contact_addr_1			
medical_record_contact_addr_2			
medical_record_contact_city			
medical_record_contact_state			
medical_record_contact_zip_code			
medical_record_contact_phone			
dos_from_line			
dos_to_line			

Standard Details Field Name	State Details Field Name *(if different form Standard Field Name)*	Filename Containing Data Layouts and Decodes	Explanation for Missing Data or Additional Information *(if any)*
place_of_svc			
type_of_svc			
ndc_code			
drug_order_dt			
rx_num			
prior_auth_num			
date_of_payment_line			
sampling_unit_level			
icd_version			
billed_units			
bill_type			
billed_proc_code			
billed_rev_code			
billed_amt			
federal_claim_category			
recip_elig_type			
recipient_elig_cat			
recipient_death_date			
user_field_1			
user_field_2			
user_field_3			

Standard Details Field Name	State Details Field Name *(if different form Standard Field Name)*	Filename Containing Data Layouts and Decodes	Explanation for Missing Data or Additional Information *(if any)*
user_field_4			
user_field_5			
user_field_6			
user_field_7			
user_field_8			
user_field_9			
user_field_10			

Appendix C: PERM Transmission Cover Sheets

These forms will also be provided to the state in MS Excel (".xlsx" file format).

Transmission Cover Sheet

PERM Details File

State:

Date:

Quarter:

Data Descriptions: *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)				

Control Totals: *If submitting more than two data files, copy and paste additional control totals tables.*
NOTE: 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.

Data Filename:

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)								

Data Filename:

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)								