RY 2020 PERM Plus Data Submission Instructions

June 2018

Table of Contents

1. Overview

The Improper Payments Information Act (IPIA) of 2002[1], as amended, requires the heads of federal agencies to annually review programs they administer and identify those that may be susceptible to significant improper payments, to estimate the amount of improper payments, to submit those estimates to Congress, and to submit a report on actions the agency is taking to reduce the improper payments. Medicaid and the Children's Health Insurance Program (CHIP) were identified as programs at risk for significant improper payments.

CMS developed the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and CHIP and produce improper payment rates for each program. The improper payment rates are based on reviews of the Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the Review Year (RY) under review.

To compute the PERM improper payment rates, all of the Medicaid and CHIP claims that were paid or denied during the federal RY under review are submitted by each state to CMS' Statistical Contractor (SC). The data requests for PERM are large and complex: the claims and payment data required for PERM include essentially all of a state's Medicaid and CHIP recipient-specific payments and many aggregate payments (together referred to as the PERM "universe"), as well as recipient and provider information for claims that are sampled for review.

These instructions are intended to guide state staff in the preparation and submission of claims data to the PERM SC. The instructions include information about PERM program areas that are measured, required variables to be submitted, state Quality Control (QC) checks, and data submission security requirements. Appendices include tables of required fields, a Transmission Cover Sheet for QC verification, and specific differences between the fiscal year (FY) 2016 and reporting year (RY) 2020 PERM cycles.

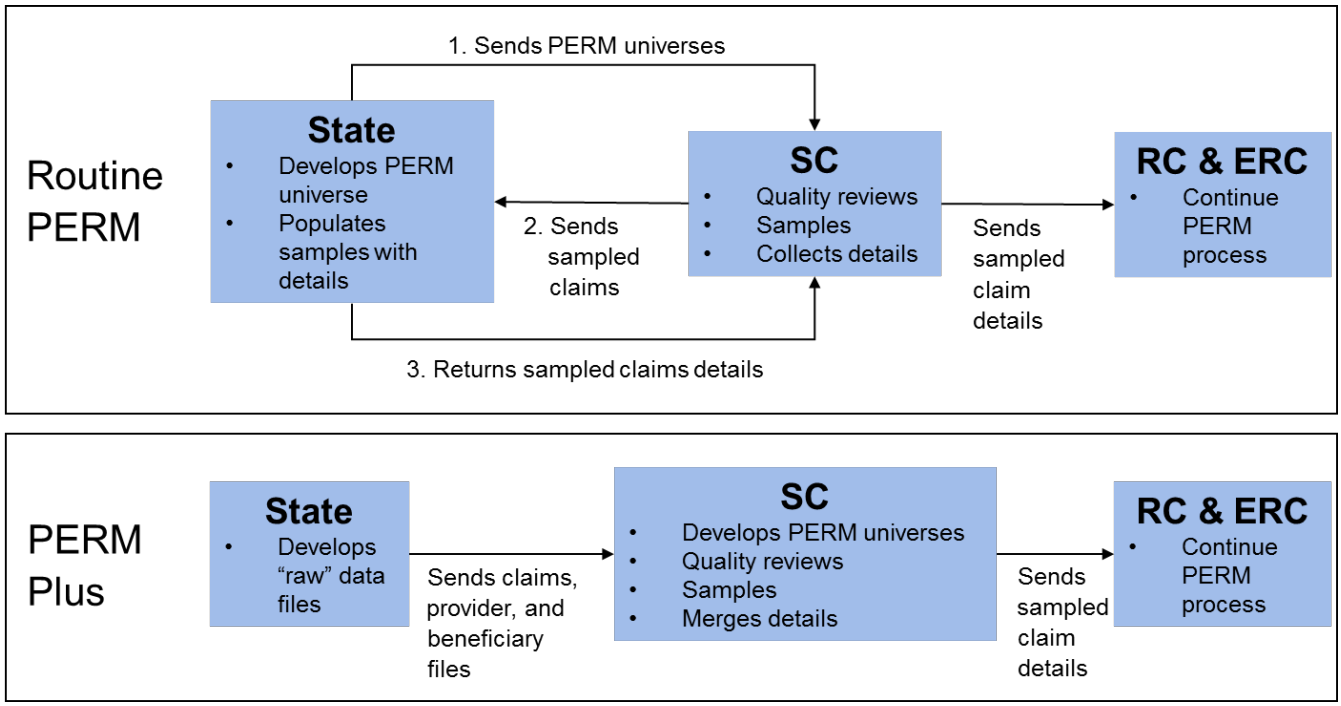
Each member of the state's PERM team, including technical and non-technical staff from the state and any relevant vendors, should receive a copy of these instructions and review them early in the PERM cycle but no later than prior to the state data intake meeting.

1.1 PERM+ Process Overview

PERM+ is an innovative way for states, CMS, and the CMS PERM contractors to approach data submission for the claims and payments portion of PERM. PERM+ simplifies the PERM data submission process for the states, as claim, recipient, and provider data are submitted simultaneously, eliminating the need for states to submit additional information prior to requesting medical records. Exhibit 1 compares data flow for routine PERM and PERM+.

[1] As amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 and by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012.

Exhibit 1: Data Flow in Routine PERM and PERM+



PERM+ generally requires less upfront analysis and data modifications by the state because the PERM SC, not the state, will be responsible for assigning and extracting data as "sampling units" (e.g., determining if a claim or payment should be sampled at the header or line level based on the payment methodology, removing records that do not qualify for sampling) and dividing the PERM+ data submissions into FFS and managed care datasets for sampling. However, state assistance is necessary for the SC to understand the data and accurately build universes that meet PERM requirements.

1.2 Initial Preparations for PERM+

In early quarters, the amount of assistance needed may be higher so the state and SC may communicate specifications while acclimating to PERM needs.

It is imperative that correct universe data are provided to the SC during the cycle so that the sampling universe is accurate, contains all required payments, and reflects the data present in the state systems. When inaccurate or incomplete data is provided this results in delays creating samples and details, can lead to oversamples and resamples of universes, and can complicate the eligibility, data processing, and medical records reviews by the other contractors. This document is intended to provide the states with information critical to creating an accurate universe.

All contractors work together with the state during the PERM process. At the start of the cycle, the SC will work closely with the state to:

- Assist each state in interpreting and applying the PERM data submission instructions included in this document.

- Schedule meetings with state staff at the beginning of the PERM cycle to discuss the data request and to learn in detail about how the state adjudicates claims and processes other payments.
- Work with state staff to be certain that the state submitted all of the required PERM data in their data submissions.
- Respond to state questions throughout the process to ensure mutual understanding of the data requirements and specifications.

To help ensure that all required data are included in the PERM+ submissions, each state should develop a PERM team that includes program, policy, technical and budget staff. From experience, CMS has identified that effective PERM teams include both state and vendor staff with expertise in areas such as:

- **Program structure:** Includes staff from the single state agency and other designated state agencies who are responsible for and knowledgeable of:
  - Medicaid and CHIP program administration, development of state regulations and policies, and coordination across the organization(s)
  - Managed care program design, contract administration and oversight, and quality measurement
  - Reimbursement policies for state plan services, rate development for at-risk and/or partial risk contracts, and cost reconciliation arrangements
  - Claims, billing, and payment mechanisms for all federally matched Title XIX and XXI services
  - State-only funded and waiver programs adjudicated in MMIS
- **Data sources:** Includes state staff and contractors responsible for the implementation and ongoing support of:
  - The state's Medicaid Management Information System (MMIS) and any Third Party Administrator (TPA)
  - Health insurance premium payment (HIPP) program and payments
  - Pharmacy Benefit Manager (PBM)
  - Behavioral Health programs
  - Other state agencies, systems, and vendors responsible for claims, payments, adjudications, or data warehousing
- **Technical aspects of claims adjudication:** Includes staff knowledgeable of data components and processing and those who can apply PERM requirements to identify necessary fields that indicate certain considerations for PERM, including:
  - Definition of paid date
  - Treatment of adjustments, denied/voided/rejected claims
  - Services matched with certified public expenditures (CPEs) and the amount
  - Co-pays and Third Party Liability (TPL)
  - Claims billed using local procedure, revenue, or place or service codes
  - Provider contact information for medical and data processing review requests

  - Recipient information
  - Original paid date
- **Budget and finance:** Includes staff who are responsible for developing and submitting federal matching fund reports (e.g., quarterly CMS-64 and CMS-21 reports)

1.3 File Development and Submission Timeline

The PERM project cycle is expected to take approximately two years, with claims and payment record collection and sampling activities concentrated in the first four quarters (with states submitting data quarterly beginning October 15, 2018) and improper payment rate calculation occurring at the end of the review cycle.

Exhibit 2 outlines the major activities in the data submission process, with data submission dates highlighted in yellow. To meet the PERM project deadlines, it is important to:

- Begin development of the PERM data submissions as early as possible in the cycle. States should expect to spend time in the first quarter (Q1) of the RY of the measurement (July through September 2018) preparing for the first quarter data submission in October.
- Expect to spend time in October through December responding to questions about the PERM universe and resolving any data issues found during data validation and QC. Subsequent data submissions are due in January, April, and July.

Exhibit 2: Major Activities of Data Submission Process

Date	State Activities	SC/CMS Activities
May -June 2018	• Determine if the state will submit via PERM Plus or routine PERM • Select PERM team • Provide completed State Information and State Contact Surveys and applicable data dictionaries • Participate in PERM 101 education sessions	• Meet with select states to discuss the PERM Plus submission option • Answer questions about PERM • Send final component sample sizes to each state
June - July 2018	• Schedule state orientation meeting	• Organize state Intake Meeting
August – September 2018	• Participate in a state Intake Meeting • Review, update, and approve notes from Intake Meeting • Review Data Submission Instructions • Ask questions and provide feedback • Test SC secure file transfer site	• Participate in state Intake Meetings • Develop draft notes from Intake Meeting, modify based on feedback, and send final version • Answer questions from and provide feedback to PERM states • Request and set up secure file transfer accounts for designated state users

Date	State Activities	SC/CMS Activities
September 2018	• Code programs to provide PERM data sets • Conduct QC review of PERM universe data and submit test data to ensure its compliance with requirements • Ask questions and provide feedback	• Answer questions from and provide feedback to PERM states
October 15, 2018	• Submit Q1 PERM universe data to the SC	• Receive Q1 PERM universe data from states
October 15 – November 2018	• Work with SC to verify payment levels for each type of claim • Work with SC to resolve issues identified during the data validation and QC process	• Confirm payment levels for each type of claim • Begin SC data validation and QC process
November – December 2018	• Work with SC to resolve issues identified during QC of PERM universes	• Perform QC review of PERM universes • Select Q1 samples • Schedule Details Intake Meeting with state
Within 30 days	• Work with SC to resolve issues	• Finalize details data and transmit the formatted details to the RC
January 15, 2019	• Submit Q2 PERM universe data to the SC	• Receive Q2 PERM universe data from states
January 15 – March 2019	• Work with SC to resolve issues	• Perform QC review of PERM universes • Select Q2 samples
Within 30 days	• Work with SC to resolve issues	• Finalize details data and transmit the formatted details to the RC
April 15, 2019	• Submit Q3 PERM universe data to the SC	• Receive Q3 PERM universe data from states
April 15 – June 2019	• Work with SC to resolve issues • Review CMS-64 analysis and provide feedback to SC as necessary	• Perform QC review of PERM universes • Select Q3 samples • Conduct CMS-64 comparison and analysis
Within 30 days	• Work with SC to resolve issues	• Finalize details data and transmit the formatted details to the RC
July 15, 2019	• Submit Q4 PERM universe data to the SC	• Receive Q4 PERM universe data from states
July 15 – September, 2019	• Work with SC to resolve issues	• Perform QC review of PERM universes • Select Q4 samples

Date	State Activities	SC/CMS Activities
Within 30 days	• Work with SC to resolve issues	• Finalize details data and transmit the formatted details to the RC

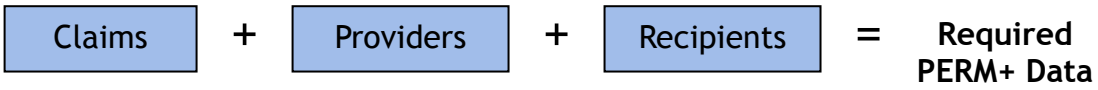
2. PERM+ Data File Specifications

This section addresses the content of the PERM+ data submissions, including the structure of the submission, PERM payment inclusions and exclusions, and descriptions of the required fields along with requirements for those fields.

2.1 File Structure

For PERM+, the states submit data files to the SC containing all fields required for sampling, data processing review, and medical record request and review (see Exhibit 3). Note that all required fields for all claims types might not be in the same system. States submit PERM+ data in three files: claim information, recipient information, and provider information.

Exhibit 3: Claims, Provider, and Recipient Data are Required for PERM+ Submissions



2.1.1 Claim Header and Claim Detail Files

Generally, states include in the PERM+ data submission all recipient-level Medicaid and CHIP claims and payments that are matched with either federal Title XIX or Title XXI funds.

States may also make payments in aggregate based on recipient-level information. States and the SC will work together to determine a plan for submitting aggregate payments.

PERM+ offers states flexibility in the structure of the data files submitted to the SC. PERM+ states may submit:

- One file with claim headers and a second file with claim details
- One file with both claim header and detail data
- Another combination of files (e.g., institutional and practitioner claims in separate files)

The SC will work with the state to determine the most appropriate file structure.

2.1.2 Recipient and Provider Files

The PERM Review Contractor (RC) and Eligibility Review Contractor (ERC) requires recipient and provider information for sampled claims to request medical records from providers and to conduct the medical, data processing, and eligibility reviews. Therefore, states submit recipient information (e.g., name, date of birth) and provider information (e.g., address, provider type) as

separate files in the PERM+ submissions. For each sampled claim, the SC will use the recipient and provider numbers to "match" to the recipient and provider information in the separate files.

When developing the provider file, states should include all available provider records regardless of the provider's status as an active or inactive provider. States should also include all providers – billing, performing (servicing/rendering/attending) and referring (prescribing) – in the provider file.

When developing the recipient file, states should include recipient records for all recipients who have a claim in the PERM claims file. The SC will work with states to satisfy these requirements for the provider file and the recipient file.

Special Note about Provider Fields

Since the number and type of provider information has changed, the following explains the differences in what is being asked for in each field:

Required for all claims:

- Billing Provider – These fields should be populated with information about the provider who submitted the services for reimbursement.

Required for claims paid at the line level:

- Performing/Servicing Provider – This is the provider who performed or provided the service to the recipient.

Required for certain claim types:

- Referring Provider –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 is required for claims for lab, x-rays, physical/occupations/speech therapy, durable medical equipment, prosthetics and orthotics.
- Prescribing provider – This is required for pharmacy claims and is the physician who prescribed the medication or supply for the recipient.
- Attending provider – This is required for institutional claims and should link back to an individual provider and not an institution.

2.2 Universe Parameters

The PERM+ data submission is primarily defined by three major parameters that have PERM specific definitions, each of which is described in more detail below.

- Program Type
- Date
- Paid Amount

This section defines and discusses three primary PERM universe parameters as well as provides guidance on other areas that are critical to the submission of a complete and accurate PERM

universe including: the treatment of denied and zero-paid claims; payments and records excluded from PERM; and PERM data sources.

2.2.1 Program Type

The PERM data submission can include up to four data universes, depending on the program structure and service delivery systems operating in each state. Universes can include:

- Medicaid FFS
- CHIP FFS
- Medicaid managed care
- CHIP managed care

How each universe must be defined for PERM may be different than a state's definitions of each program. Identification of Medicaid and CHIP and the division between FFS and managed care is discussed further in the following sections.

2.2.2 Identifying Medicaid and CHIP

States include both Title XIX and Title XXI matched payments in the PERM data submissions. As CMS must report separate improper payment rates for the Medicaid and CHIP programs, the state must separate PERM data submissions between Title XIX and Title XXI and submit these in separate PERM universe files for each quarter. States should separate claims into the Medicaid or CHIP universe based on:

1) **Source of federal money, not the program design.** All payments matched with Medicaid Title XIX Federal Financial Participation (FFP) should be identified as Medicaid and submitted in the PERM Medicaid universe file. All payments matched with Title XXI FFP should be identified as CHIP and submitted in the CHIP universe file. This includes standalone CHIP (SCHIP) programs and CHIP-funded Medicaid expansion (MCHIP) programs. MCHIP Payments that are considered part of "Medicaid" by the State but matched with Title XXI should be identified as CHIP for PERM purposes. States with SCHIP and MCHIP programs should identify all payments from those programs as CHIP
2) **The recipient's eligibility status during the dates of service at the time the claim was paid (adjudicated), not the recipient's eligibility status at the time the state selects the data for PERM.** Since it is possible that individual's eligibility could change from the time a service is received to when the PERM data is pulled based on original paid date, it is imperative that states develop universe programming which identifies the funding source of the claim (XIX or XXI) rather than the recipient's program eligibility at the time the PERM universe is pulled for submission.

States are required to include in the PERM claims file all payments that are paid for in whole or in part by Title XIX FFP dollars, as well as those payments considered for Title XIX FFP dollars but denied.

The Fields for Universe Submission table in Appendix A also includes a field called "funding code." States may populate this field with any state-specific value that identifies, or helps identify, the state requested federal Title XIX or Title XXI match for the claim or payment. If your state has difficulty distinguishing between Title XIX and Title XXI payments, please notify the SC who will work with state staff to find an appropriate solution.

Include in the PERM claims file all Medicaid expansion and/or stand-alone CHIP payments in the PERM submission, including payments that are paid for in whole or in part by Title XXI FFP dollars, as well as payments submitted as Title XXI services but denied. This includes any paid or denied claims that are adjudicated by and/or stored with third party data vendors.

2.2.3 Identifying Fee-For-Service and Managed Care for PERM

In addition to separately measuring Medicaid (Title XIX) and CHIP (Title XXI), PERM also independently measures fee-for-service (FFS) and managed care, as applicable, for each state. Referred to as "component" measurements, FFS and managed care have PERM-specific definitions which may differ from how states define each mode of service delivery. Further, PERM also has additional inclusion rules that are necessary to ensure a complete and accurate PERM universe. Below is an overview of how PERM defines each "component" as well as information on what types of records are included in each "component" universe.

During each state's intake discussion, the SC will discuss these component definitions in more detail with the state to ensure that data provided is consistent and compliant with PERM guidance as well as to support the state in determining where specific payments should be assigned for PERM purposes.

2.2.3.1 Fee-For-Service Universe

The PERM FFS universe includes three primary types of Medicaid and CHIP payments.

1) Traditional FFS claims

The FFS universe is comprised of all payments made on a FFS/indemnity basis, including:

- Traditional FFS payments to physicians, hospitals, pharmacies, home health agencies, Long-Term Care (LTC) facilities, etc.
- Medicare crossover claims
- FFS claims for services carved out of managed care
- FFS claims paid for retroactive eligibility periods

2) Fixed non-risk payments

In addition to "traditional" FFS payments, the PERM FFS universe also includes other types of payments referred to as "fixed" for PERM purposes. These payments are often capitated, Per Member Per Month (PMPM) payments and/or could be system-generated, non-medical, or

administrative-like payments that would not require a PERM medical record review like other PERM FFS claim payments. Examples of PERM "fixed" payments include a variety of payments made to providers or vendors, such as:

- Monthly Primary Care Case Management (PCCM), Health Home, or Patient Centered Medical Home (PCMH) fees paid to participating providers
- Health Insurance Premium Payment (HIPP) payments made to purchase or subsidize employer-sponsored insurance
- Capitated non-emergency transportation broker payments
- Fixed recipient-specific pharmacy dispensing fees (e.g., a state pays nursing home pharmacies a monthly fixed amount per recipient)
- Reinsurance payments
- Managed care stop loss payments
- Supplemental payments made to managed care organizations based on service type (FQHC for example) or geographic region

The SC will work with the state to evaluate state programs and services and determine if any meet the PERM "fixed" payment definition and should be included in the FFS universe.

3) Aggregate payments

While most Medicaid and CHIP payments for services are paid at the recipient level, states may calculate and pay for some services on behalf of a group of recipients. PERM classifies these as "aggregate payments" which are payments made for a group of recipients where individual payment records are not readily available or cannot easily be re-created. Unless otherwise specified by CMS, all payments for services to recipients are included in the PERM universe, regardless of whether the state claims FFP at the medical services match rate or as an allowable administrative cost. The SC will work with the state to determine whether certain payments should be classified as "aggregate payments" for the purposes of PERM. Examples of aggregate payments include:

- Reimbursement to counties for non-emergency transportation services provided to all Medicaid recipients residing in that county
- Contractual payment to a broker for services (e.g. transportation) that cannot be identified at the recipient level
- Fees paid to a case management vendor based on the number of recipients enrolled in the Medicaid program each month

In some cases, states may determine payment at the individual level but maintain payment records at the aggregate level. CMS and the SC will work with the state to determine how aggregate payments should be submitted and reviewed for PERM. For example, some states make supplemental payments for FQHC services provided to recipients in an MCO. While we usually see these payments made at the recipient level, states sometimes have the payment data available at the MCO level only. In this case the payments would be moved to the FFS fixed payments strata for sampling. It is critical that states raise all possible

aggregate payments to CMS and the SC for discussion so that all payments required for PERM review are included in a universe.

4) Other Payments

States may need to submit other types of payments as part of the PERM universe.

- **Incentive Payments**: There are many states with new programs that make supplemental or "bump" payments for certain types of services. Examples of these payments include difficulty of care payments made to ICF/IIDs for recipients with developmental disabilities, 1202 "bump" payments made to primary care physicians, and health home incentive payments. These are usually small dollar payments that can be tied to individual recipients and services. In rare instances, these payments are made to providers on the aggregate level.
    - Not all incentive payments meet the requirements for inclusion in the PERM universe. For example, pay-for-performance payments are excluded.
    - If your state makes any supplemental payments to providers, you should notify the SC and explain in what types of situations these payments are made and on what basis. A determination can be made at that point as to whether or not the claims need to be submitted as part of the PERM universe.
- **Financial Transactions**: The SC usually sees this type of payment for services that are not submitted via the MMIS and for which records are usually kept on paper or spreadsheets. There are numerous situations in which a payment may be made via this method, including payments for services given to qualified aliens, reimbursements for transportation to caregivers, payments for interpreter services, and reimbursements for out-of-pocket expenses.
    - In these types of situations the state needs to discuss these payments with the SC to determine what the payments are for, if they should be included in the sampling universe, the payment level of the claim, and what information the state will need to submit in the universe data for these payments.
- **Wrap-around payments**: This is a supplemental payment, usually made to an MCO to increase the reimbursement for certain types of services. We see this most often with FQHC/RHC services. These wrap around payments provide for supplemental payments from states to FQHCs and RHCs equal to the amount or difference between the payment under the FFS methodology and the payment provided under the managed care contract.
    - If your state makes these types of payments, you need to notify the SC during the intake meeting process.
- ASO programs - Payments made to an organization under an Administrative Services Only (ASO) arrangement would be included in the FFS universe. ASOs generally are contracted to manage claims and benefits while bearing little or no risk for the cost of delivering care. There are typically two different scenarios for ASO payments. In the first scenario, ASOs receive an Advance PMPM for patient care. Providers bill the ASO for services received by the recipients. The PMPM payment is used by the ASO to pay claims incurred by members. In many cases the payments

are later reconciled with the state to the actual claim amounts. In these cases the state maintains the risk. In the second scenario, the ASO is budgeted for a target amount for a set period of time (e.g., a year), but goes over the set amount in reimbursement of services. The ASO will be reimbursed for the difference by the state, and therefore all the risk is maintained by the state.

- The SC will work with each state to evaluate state programs and determine if program payments conform to the PERM managed care definition or if the payments should be included in the FFS universe instead. Please be prepared to discuss any ASO arrangements in your state with the SC during the Intake Meeting.

2.2.3.2 Managed Care Universe

For the purposes of PERM, the managed care universe consists of payments made by the State to "at-risk" organizations that provide services to their assigned beneficiaries. These payments are not individual claim payments or reimbursements for individual claims payments. These are typically capitation payments that cover multiple services for which the organization, and not the state, are at financial risk for. These payments, and not the claim payments made by the organizations, are subject to Federal match, and are therefore reviewed under PERM.

Full Risk Managed Care Program

A provider organization, or group of organizations, receive from the payer a set payment per patient for specified medical services. In this way, the provider takes on 100% of the insurance risk for the covered patient and services.

Partial Risk Managed Care Program

Managed care plan pays providers prospectively for a subset of services, such as case management or crisis services, with other services reimbursed on a FFS basis. The plan may be at risk for costs or gains that exceed a predetermined cost for the services covered under the partial risk program.

These payments include:

- Premiums for "capitated" or "full risk" arrangements, such as payments to Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs), Pre-paid Inpatient Hospital Plans (PIHPs), and Health Insurance Organizations (HIOs);
- Payments to service-specific providers paid as part of capitated arrangements (e.g., PBMs, behavioral health MCOs);
- Condition-specific capitation payments for special needs recipients (e.g., at-risk payments for services provided to people living with HIV/AIDS) who are enrolled in a specialized managed care program; and
- Certain non-capitated, recipient-specific payments made to MCOs such as newborn delivery supplemental payments or "kick" payments, which include multiple services, are paid at a negotiated rate and not paid on a FFS basis.

While full-risk payments to MCOs are clearly part of the managed care universe, payments associated with certain types of capitated programs may be more appropriately included in the FFS universe (see Capitated Non-Risk Payments, above). The PERM SC will discuss each state

program during the data intake process and will work with the state to determine the appropriate universe (FFS or managed care) for each type of payment.

The RC can only accept single-line managed care claims. Inform the SC about claims for any type of program that have multiple lines (e.g. one line to reflect a behavioral health payment and another to reflect a physical health payment) so that the SC can determine the best way to create a sampling universe and supply the RC with all the information needed to complete the data processing review.

2.2.4 Date

PERM universes include claims and payments originally paid during the RY under review. To support consistency across states, PERM relies on the original paid date to determine whether a payment falls within a given cycle measurement.

- If a state originally paid a claim during the cycle under review, but adjusted the claim after the PERM measurement period, the claim should be included in the PERM data submission based on the original paid date
- Conversely, if a claim's original paid date is prior to the PERM measurement period, but an adjustment falls within the PERM measurement period, the claim would not be included in the PERM data based on the original paid date

For the RY 2020 PERM cycle, the state's PERM universe includes claims and payments with original dates of payment between July 1, 2018 and June 30, 2019.

States submit PERM data quarterly, including all claims with an original date of payment within the review quarter. Data are due to the SC 15 days after the end of each quarter. See Exhibit 4 for the data submission due dates for RY 2020 and the paid claim dates to be included in each quarterly submission.

Exhibit 4: RY 2020 Quarterly PERM Data Submission Dates

RY 2020 Quarter	Claim Date Paid	Data Submission Due
Quarter 1	July 1 – September 30, 2018	October 15, 2018
Quarter 2	October 1 – December 31, 2018	January 15, 2019
Quarter 3	January 1 – March 31, 2019	April 15, 2019
Quarter 4	April 1 – June 30, 2019	July 15, 2019

States often make managed care capitation payments prospectively (e.g., on the 25th of the month prior to the month of coverage) or retrospectively (e.g., in the month following the month of coverage). Managed care capitation payments should be included in the PERM data submission based on paid date as well.

- Prospective example: A state makes a capitation payment on December 25, 2018 for services in January 2019; the state includes the payment with the PERM Q2 data submission

- Retrospective example: A state makes a capitation payment on October 5, 2018 for services in September 2018; the state should include the payment with the PERM Q2 data submission

Important notes about the dates used in the sampling universe:

States may submit the adjudication date instead of the original paid date in the PERM universe as long as the state maintains a consistent date approach throughout all four quarterly submissions. The adjudication date refers to the date that a claim is fully processed and either approved for payment or denied. The state should discuss this approach with the SC during the data intake meeting.

States may also submit certain types of claims (e.g., off-MMIS claims) using a date approach that is different from the other universe claims, as long as the dates for each data set submitted for those claims are consistent over the course of the year. For example, a state could submit all MMIS claims using adjudication date but submit all off-MMIS waiver claims from sister agencies using paid date.

The SC will review the dates that are included for each data source with the state at the beginning of the cycle and will work with the state to identify the best date field for determining the PERM universe for each quarter. This information will be relayed to the RC and ERC for use during the data processing and eligibility reviews.

2.2.5 Paid Amount

The paid amount for each claim and payment in PERM should reflect the original, non-adjusted total computable paid amount. The total computable paid amount is the federal share plus the state and/or local share of the payment. CHIP and Medicaid are jointly funded by the federal and state governments. As such, both funding sources should be represented in the total computable paid amount.

The total computable paid amount should not include recipient cost sharing amounts, such as patient liability (co-pays, contribution to care), TPL, or any other non-Title XIX or Title XXI matched dollars (e.g., taxes paid on waiver services).

For certified public expenditures (CPEs) such as school-based services or payments to public hospitals, the state must provide both the federal and state/local share for the PERM paid amount even if the paid amount in the payment system only reflects the federal share for which match is claimed. Please discuss with the SC any CPEs or other payments where the paid amount in the state's payment system might not reflect the PERM-defined total computable paid amount.

2.3 Additional PERM Universe Specifications

In addition to the three main parameters identified above, PERM universes must also meet additional specifications.

2.3.1 Denied and Zero-Paid Claims

In both the FFS and managed care universes, as defined above, states should include the following types of records, as applicable.

2.3.1.1 Denied Claims

Denied claims are claims that are adjudicated in the state's payment system but denied for payment. States submit denied claims as part of the state's PERM+ data submission. Denied claims from vendor payment systems must be included in the PERM+ data submission if the claims are program claims that are not found in the state MMIS. In certain instances, states may not be able to determine if a denied claim should be assigned to the Title XIX or the Title XXI program (e.g., a claim that is denied due to an invalid recipient identifier). Please discuss the treatment of these denied claims with the SC.

2.3.1.2 Zero-Paid Claims

A zero-paid claim is a claim for which the state had no financial liability. For example, claims may be zero-paid due to TPL, a Medicare crossover payment exceeding the state allowable charge, or for spend-down recipients who have not met their financial obligations. Include zero-paid claims in the PERM+ data submission.

2.3.2 Service Expenditures Matched at the Administrative Rate

PERM includes payments made for medical services received by individual recipients that are matched either at the medical Federal Medical Assistance Percentage (FMAP) or that receive FFP as an allowable administrative cost. The most common medical services that may be matched with administrative funds include NET or HIPP payments. Please discuss with the SC any services that are considered an allowable administrative cost, but could be considered a medical service to determine if the service payments should be reported for PERM.

2.3.3 Claims and Payments Excluded from the PERM Universe

Below we provide some specific guidance regarding what types of payments, claims, and records are excluded from the PERM universe. Certain claims and payments for which states receive FFP through Title XIX or Title XXI are explicitly excluded from PERM either by regulation or in accordance with established policy. During the intake meeting, the SC will discuss these exclusions in more detail with each state to ensure that each state's specific data submission is compliant with PERM requirements regarding excluded data.

2.3.4 Payments Excluded by Regulation

The PERM regulation explicitly excludes a small number of specific payment types from the universe, when not paid at the individual recipient-level.[2]

- Disproportionate Share Hospital (DSH) payments

[2] States may include these in the PERM+ submissions if the payments are readily identifiable and the state instructs the SC to remove the payments prior to sampling.

- Drug rebates
- Grants to state agencies or local health departments
- Cost-based reconciliations to not-for-profit providers or Federally Qualified Health Centers (FQHCs)
- Mass adjustments
- Lump-sum Graduate Medical Education (GME) payments
- Express Lane Eligibility (ELE) claims are excluded from eligibility reviews

2.3.5 State-only and Other Non-Title XIX /Non-Title XXI Payments

Not all claims processed in MMIS are matched with Title XIX or Title XXI funds. Only claims and payments matched with Title XIX and Title XXI federal funds are included in PERM. PERM+ states may include state-only or other federally funded claims and payments in the PERM+ submissions, however, the states must provide documentation and guidance that will allow the SC to exclude these payments from the PERM universes.

2.3.6 Medicare Part A and Part B Premium Payments

States should not include Medicare Part A and Part B premium payments in the PERM data submission. The SC will collect these payments from CMS to include in each state's universe prior to sampling. Any premium payments that are sampled will be sent to the states and are subject to data processing review.

2.3.7 Informational-only Data

States should not include informational-only data in the PERM submissions. Informational-only data is defined as records maintained in the state or vendor payment system that do not represent actual payment to a provider. Examples include supporting service lines submitted with an inpatient hospital claim paid via Diagnosis-Related group (DRG) payment or with an encounter rate from an FQHC. In both examples, states should only submit the record that was the basis for payment (e.g., DRG or T1015 encounter rate). PERM+ states may include informational-only data in the PERM+ submissions, however, the state must provide documentation and guidance that will allow the SC to exclude these from the PERM universes.

2.3.8 Encounter Data

States must not include encounter data or "shadow claims" in the PERM submissions. For PERM purposes, encounter data is defined as informational-only records submitted to a state by managed care contractors under an at-risk contract with the State. The records include claims paid by the contractor for services covered under a managed care capitation payment. States often collect this data in order to track utilization, assess access to care, and possibly compute risk adjustment factors for use in risk-adjusting capitation payments. While encounter data records are recipient-specific, they do not represent an actual payment made by the state. As a result, these claims are not subject to FFP, and as a result, not included in PERM.

2.3.9 Rejected Claims

States should only include fully adjudicated claims and payments in the PERM submissions. Claims that are submitted by providers that are "rejected" from the claims processing system prior to adjudication are not part of the PERM review. Often claim rejection occurs in a pre-processor or translator prior to the system assigning the claim an internal control number. PERM+ states may include rejected claims in the PERM+ submissions; however in that case, the states must provide documentation and guidance that will allow the SC to exclude these from the PERM universes.

2.3.10 Payments for Administrative Functions

As noted above, PERM claims and payments represent services to recipients. Payments made entirely for administrative functions are not included in the PERM review and states should not include these in the PERM submissions. These include payments such as state staff salaries, fiscal agents and other administrative vendors, and outreach funding. For cases in which a state blends dollars for recipient services with administrative payments into a single reimbursement rate, the state should submit the entire payment for PERM review.

2.3.11 Adjusted Claims

Only original claims and payments are included in PERM. PERM+ states may include adjusted claims and payments in the PERM+ submissions, however in that case, the states should provide documentation and guidance that will allow the SC to exclude any adjustments or refunds from the PERM universes. *Please notify the SC if your state uses a void and replace system.*

2.4 Data Sources

States generally extract a majority of PERM+ data from their MMIS. However, states often maintain other payment systems that record payments matched with Title XIX or Title XXI funds (and for which the state does not also maintain a payment recorded in MMIS). States must include all payments, including those from non-MMIS systems, in the PERM+ data submissions. PERM+ affords states flexibility to submit data from systems outside MMIS as separate files from the MMIS data.

When reviewing possible data sources, states are advised to consider sources such as:

- Claims paid by separate vendors or third party administrators
  - Pharmacy
  - Dental
  - Vision
  - Behavioral Health
- Claims paid by state agencies (not the Medicaid agency)
- Services for Individuals with Intellectual Disabilities or Developmental Disabilities (ID/DD)
- State-owned facilities such as nursing homes;
- Waiver services (including consumer-directed individualized budgets)

- Claims paid by counties
- Transportation provider payment systems
- Case management costs
- Stand-alone or "manual" systems
- HIPP payments
- FQHCs, Rural Health Clinics (RHC), Indian Health Service (IHS) clinics and facilities
- Systems that produce payments such as PCCM payments and non-emergency medical transportation broker capitation payments

State staff should "follow the money" by reviewing their state's federal financial reports to determine if a state is capturing payments from all of the data sources. If a state determines that data from multiple sources populates the CMS-64 and/or CMS-21 Financial Reports, the state should evaluate these data sources to identify claims and payments to include in the PERM data submission.

2.5 Payment Level in the PERM+ Submission

There is much emphasis on states submitting PERM data at the correct "payment level" (i.e., states submit at the header or line based on how the claim is priced and paid) in Routine PERM. However for PERM+, the SC, not the state, is responsible for establishing the correct payment level for each claim or payment.

States need to submit both header and detail/line records for all claims for PERM+. States also need to provide guidance to help the SC identify header and detail records in the claims submission. **Submitting all of the header and detail information for a claim is a key difference between the PERM+ data submission and the routine PERM data submission.**

The SC will discuss with states the various payment methodologies for claims to understand how different types of claims are adjudicated and paid. The SC will then use the claims and payment data and guidance from the state to identify the appropriate claim payment level and develop the PERM sampling units.

Correctly identifying how claims are paid is important for sampling claims at the correct level; errors at this stage can lead to oversamples late in the cycle.

PERM defines a sampling unit as the smallest, individually priced and paid unit available. The PERM universe will have one record for each sampling unit. States must provide universe data at the sampling unit level.

Individual recipient-level FFS claims are typically submitted at the line or claim (header) level. A broad definition is provided below and more detail is provided in the following sections.

- **Line level**: If a payment amount is determined to be at the "line" level for each specific service provided, the sampling unit is the line level; each clam line has an opportunity to be

sampled; this applies to most physician and outpatient claims that have multiple paid lines on each claim.

- **Header level**: If the payment amount is determined to be at the claim level, the sampling unit is at the claim or "header" level; a header level sampling unit has a paid amount that is not associated with any specific line or service; rather, it is based on days, groups of services and/or other related information, encounter rates, or point of sale transactions; this applies primarily to inpatient and pharmacy claims where there are no separate line-level payments.

Important notes about payment level determinations:

- For FFS claims, note that if payment amount determination is made for the claim as a whole, regardless of the number of lines, and the individual lines are informational but not used for payment, it is a header level payment. If each line in a claim stands the chance of being paid or denied individually, these are line level payments.
- For managed care payments made to full-risk entities and for payments made to partial-risk or non-risk entities on a PMPM basis, the sampling unit is typically the capitated amount that is paid each month on behalf of the Medicaid or CHIP enrollee. When an actual payment to an entity spans multiple months of coverage, the sampling unit would be the total amount paid to the entity for the enrollee at one time.
- For aggregate payments, CMS, the SC and the RC will work with your state on each payment identified to determine the smallest paid amount available for electronic submission. For example, an aggregate payment sampling unit could be a monthly payment to a county for all transportation provided to Medicaid enrollees in that month or a quarterly pay-for-performance payment to a provider based on the provision of a certain number or set of services provided to individual enrollees.

2.5.1 Payment Level and Third Party Liability

TPL is the portion of the allowed Medicaid/CHIP reimbursement that is paid by other insurance or the recipient. As mentioned earlier in this document, the total computable amount submitted in the claims universe should not contain any TPL payments. Including this amount in the paid amount field can result in not only in claims being sampled in the incorrect strata but can also lead to cause re-sampling or over-sampling if the TPL is take out at a different level than the claim is typically paid.

To accurately report the amount that Medicaid or CHIP paid for services excluding TPL for PERM, states should submit line level claims, such as physician claims, where TPL is reported at the header level as header level sampling units. For most states, only the claims with TPL would be reported as header level sampling units. Claims without TPL should be reported as line level sampling units.

The state should review with the SC any recipient cost-sharing policies and requirements – such as co-pays and deductibles - before preparing data submissions. The state will need to identify how cost-sharing is reflected in the data and at what level federal match is provided (i.e., claim paid amount or individual line paid amount) to ensure the total computable paid amount is accurately identified. Identification of claims with TPL is vital to ensuring that claims are both sampled at the correct level and accurately reflect the total computable amount.

2.5.2 Payment Level Identification Challenges

For certain types of claims and payments, it can be difficult to accurately identify the appropriate "payment level" for PERM purposes. States should pay particular attention to certain types of claims for which the payment level might differ from other payments for similar services and communicate those to the SC. Examples are discussed below.

- **FQHC payments and other clinic payments:** In some states, FQHCs also submit unpaid or $0 paid informational line details with procedure codes. These informational line items should not be included in the PERM universe (as discussed in Claims and Payments Excluded from the PERM Universe, above).
- **Medicare crossover claims:** Medicare crossover claims are often paid on the basis of the type of service, and the universe file will need to capture these payments at the header or line item level, as appropriate to each payment. States need to provide the SC direction about the best way to identify crossover claims in the universe data.
- **Payments made to state-owned facilities or out-of-state facilities:** Some states pay state-owned facilities differently than private providers. If this is the case, be certain to select the appropriate header or line value for the PERM universe.
- **Compound drugs:** Many time the payment rate for compound drugs is different than for other pharmacy claims. Please be sure to verify the payment level for these claims and ensure that, at the details stage, all billed NDCs can be provided to the SC.
- **Clinic claims:** Clinic claims paid under an all-inclusive code (i.e. T1015) are treated similarly to header level claims. Only the line with the all-inclusive code will be eligible for sampling. All other lines are informational only and should not be subject to sampling.
- **Multiple units of service:** Multiple units of service recorded on a single line should not be divided into multiple sampling units if the units were priced and paid on the same line. For example, a procedure code having 2 units should not be made into 2 records of one unit each.

A sampling unit should never be represented multiple times within a universe file or included in more than one universe file across programs or across quarters. For line-level claims, the same ICN and line number combination should not repeat. For header-level clams, the same ICN should not repeat. If a claim is submitted at the header level, the associated lines should not be included in the universe. Likewise, if a claim is submitted at the line level, the associated header should not be included in the universe.

Again, the SC will work with the state to evaluate payments and help determine if the state should include the payment in the PERM universe at the line level or the header level.

2.5.3 Identifying Strata for Sampling Stratification

For RY 2020, the SC will use payment based stratification. The FFS universe is stratified into five dollar-weighted strata with an additional stratum for claims that cannot receive Medical Review. The managed care universe will continue to be stratified by payment amount only. The SC will assign each payment in the FFS PERM universe to one of six strata, which include:

- Fixed Payment Strata (MEDICAID) – Stratum will include fixed payments, Medicare premium payments, aggregate payments, and Medicare crossover claims. *The count of sampled claims from this stratum will be capped at no more than 10% of the sampled payments each quarter.*
- Fixed Payment Strata (CHIP) – Stratum will include fixed payments, aggregate payments, and Medicare crossover claims (if applicable).
- Five (1-5) Payment-Weighted Strata (MEDICAID AND CHIP) – All FFS claims that do not fall into one of the strata listed above will be classified into one of five payment strata. *The count of sampled claims from each payment-weighted stratum will be 2 claims at a minimum for each quarter.*

3. Changes to the RY 2020 PERM+ Data Submission Instructions from FY 2016

There have been ten updates to the required fields since the FY 2016 cycle.

General Fields	
Federal Claims Category	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.
Provider Fields	
Attending Provider	Attending provider is the specific individual providing the services to the patient. This is required for institutional claims. In previous cycles, this was noted in the performing provider field, but there are now separate attending provider fields in the layout.
Prescribing Provider	Prescribing provider – the provider who wrote the script - is required for pharmacy claims. In previous cycles, this was requested in the referring provider field, but there are now separate prescribing provider fields in the layout.
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 Fields	
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.
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.
Eligibility Fields	
Recipient Eligibility Type	This field has been added to collect information on the recipient's eligibility. This information should be identified from the state's adjudication system. It should be the eligibility of the recipient used to adjudicate the claim. All value decodes must be provided in the data dictionary.
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 be taken from the state's adjudication system.

4. Quality Review

States are responsible for performing a quality review of their PERM+ data submissions each quarter before submitting files to the SC. Quality review saves time and resources for both the state and CMS contractors by identifying data problems early in the PERM process. Exhibits 5, 6, and 7 contain suggested minimal QC checks for states to complete.

Exhibit 5: Minimum Claims File Quality Control Checks

Quality Review	Suggested Tests
1) Ensure all required fields are reported in the claims file(s)	• Prepare a list of all fields in the state's claims file and compare to the list of fields for the claims file in Appendix A • 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

Quality Review	Suggested Tests
2) Check that key fields are properly formatted and have valid values	• Check that key fields are not truncated or contain extra data. Review fields such as ▪ ICN; ▪ Line Item Number; ▪ Billing Provider Number; ▪ Recipient ID; ▪ Total Computable Amount Paid Header; ▪ Total Computable Amount Paid Line; and ▪ Dates of payment
3) Check that the dates of payment for all records are within the appropriate quarter in RY 2020	• Review the values in the paid date field • Only include payments that were adjudicated in the appropriate quarter of RY 2020
4) Confirm that the SC can identify claims as Medicaid (Title XIX) or CHIP (Title XXI)	• Review programming logic and outputs to make certain that claims in the Medicaid universe were matched with Title XIX funds and claims in the CHIP universe were matched with Title XXI funds. This check includes sharing funding source information so that the SC can identify Title XIX Federal Financial Participation (FFP) or Title XXI FFP.
5) Confirm that the SC can identify claims as FFS or Managed Care	• Confirm that data are present and documentation is available that would allow the SC to assign claims to fee-for-service or managed care universes • Review notes from intake discussion and subsequent communications with the SC and CMS to ensure the universes contain the required types of claims and payments • If PERM "fixed" payments will be submitted with the managed care data, be sure to notify the SC and provide guidance on how to identify the payments so they can be moved to FFS
6) Check that the following payment records can be identified by the SC: ▪ Adjustments and voids ▪ State-only claims ▪ Administrative payments ▪ Gross adjustments ▪ Claims matched with funds other than Title XIX or Title XXI	• Confirm that data are present and documentation is available that would allow the SC to identify and remove these records
7) Each payment is represented only one time in the claims file	• Confirm there are no ICN-line number combination is repeated in the claims file
8) Confirm that no encounter claims data is submitted in the claims file	• Remove all encounter records

Quality Review	Suggested Tests
9) Prepare to review the SC's comparison of the CMS-64/21 reports to the PERM universe submissions	• Compare PERM universe totals to either two previous quarters' CMS-64/21 reports, or to the current quarter's CMS-64/21 reports • Look for major dips or spikes or "significant" differences
10) Compare the universe size to previous quarterly submissions	• Sum number of claim lines and paid amount and compare across quarters • Note the reason for any significant changes

Exhibit 6: Minimum Recipient File Quality Control Checks

Quality Control Check	Suggested Tests
1) Make sure all required fields are reported in the recipient file	• Prepare a list of all fields in the state's recipient file and compare it to the list for the recipient file in Appendix B • Identify any missing fields • Verify there is no truncation of variable values • 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 the Recipient Number field is properly formatted	• Check that the Recipient ID field is not truncated or has additional data • Replace the data in the Recipient ID field if formatting problems are found

Exhibit 7: Minimum Provider File Quality Control Checks

Quality Control Check	Suggested Tests
1) Make sure all required fields are reported in the provider file	• Prepare a list of all fields in the state's provider file and compare it to the list for the provider file in Appendix C • 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 the Provider Number or the Provider NPI field is not truncated or has additional data depending on which field the state uses to identify providers • Replace the data in the Provider Number or the Provider NPI field if formatting problems are found • Ensure that the Provider Number is a unique identifier in the Provider File and matches the Provider Number in the Claims File (i.e., Provider information can be merged onto the claims data file supplied) • Include all billing, performing, attending for institutional claims, referring, and prescribing providers in the file

4.1 CMS-64 and CMS-21 Report Comparison to PERM Universe Data

States should compare their PERM+ data submissions to CMS-64 and CMS-21 Financial Reports, respectively, to ensure that the universes are complete and accurate. Comparing the PERM+ data to the CMS Financial Reports ensures that no programs (likely not in MMIS) that appear on the CMS Financial Reports have been omitted from the PERM+ data and that the state is capturing all necessary data sources in the PERM+ data submission.

This comparison may identify data which does not fit cleanly into the definitions previously discussed in these submission instructions. For example, the CMS Financial Reports include non-recipient-specific payments, such as aggregate provider reconciliations. When aggregate or similar payments are identified on the CMS Financial Reports, we ask that states bring this to the attention of the SC so that we can investigate whether these should be included in the PERM+ data on a case-by-case basis.

If after this comparison the state identifies Medicaid or CHIP dollars that were excluded from the PERM+ data, the state should notify the SC to coordinate the submission of the missing data. The CMS-64 and CMS-21 forms may not be finalized until after the PERM+ data are submitted, so we ask that states conduct these comparisons after the forms are finalized and as necessary review forms submitted from previous quarters to see if any adjustments were made after the initial submission that will need to be communicated to the SC during reconciliation.

The comparison that the states are asked to do is separate from the in-depth comparison that the SC will conduct throughout the cycle. The SC will identify the portions of the CMS-64 and

All claims submitted to the SC under the CHIP program should be matched with Title XXI funds; these are reported on three forms, 64.21U, 64.21U-Waiver, CMS-21. If you believe some CHIP claims submitted for PERM review are reported on any other forms, please notify the SC. No Title XXI matched claims should be included in the PERM Medicaid universe.

CMS-21 Financial Reports that are not appropriate to compare to PERM universes (excluded claims, drug rebates, adjustments, etc.), remove these from the CMS-64 and CMS-21 Financial Report Totals, and separate the CMS-64 and CMS-21 totals between FFS and managed care. If significant differences, as defined by CMS greater than 15% per quarter and 5% overall, between PERM universes and the Financial Reports are identified, the SC will contact the state to resolve the differences.

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.

5.1 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 File Transfer Protocol (SFTP). SFTP instructions will be sent to the states before the first required data submission. Any files sent via SFTP need to be encrypted and password protected. If

submission via SFTP is not an option, states may submit data on an encrypted CD or DVD. Do not send PERM data via email.

States planning to use the SFTP will be required to test their access prior to the first data submission. Please note that the Lewin SFTP has been updated since the last cycle. It now has two-factor authentication for increased security. Once the user names and passwords for your state are assigned, you will receive instructions on how to access the new SFTP site. States are encouraged to test access as early in the cycle as they are able.

See the Data Transmission section below for information on passwords and encryption.

5.2 Submission Formats

The SC prefers receiving data in one of three formats: SAS data set, delimited file, or flat file.

- SAS data set: PC-based SAS data set
- 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

5.3 Transmission Cover Sheet

The state must submit a Transmission Cover Sheet with every data submission. The Transmission Cover Sheet is used to ensure that all the data sent by the state is received by the SC, and to compare the control totals and to correct any potential data transmission errors before processing and sampling the data. Examples of the Medicaid FFS and Medicaid managed care data Transmission Cover Sheets are provided in Appendix B. The state may include 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 the SFTP. SC will not process the data further until the control totals match.

5.4 File Layouts

States are required to submit file layouts to inform the SC of the field name, length, and type (numeric versus character), and valid values as applicable. File layouts are especially useful to the SC when reading the state's quarterly data submissions.

5.5 Data Dictionary

States are required to submit a file in Excel, CSV, Word, or other text detailing the values in each variable field and what they stand for. For example, claim type variable can have values, such as: "I", "O", "3", "6", and data dictionary would indicate "I" = "Inpatient", "O" = "Outpatient", "3" = "Clinics", and "6" = "Fixed Payment". If the field has standard codes, like ICD9/10, diagnosis codes, or procedure modifiers, these variable values do not need to be provided in the data dictionary. States must ensure that valid values listed in the data dictionary match the values in the claims data.

Required tabs/pages in the data dictionary:

- Fee-for-service
  - Claim type
  - Provider Type
  - Billing Provider Specialty
  - Service Category
  - Place of Service
  - Local Codes (procedure, revenue, place of service, etc.)
- Managed care
  - Payment Type
  - Program Type

5.6 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. Data that include Protected Health Information (PHI) and/or Personally Identifiable Information (PII), such as recipient ID numbers, is considered sensitive data.

5.7 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. Contact the SC for more information.
4) Upload the zipped file to the SFTP
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

6. Appendices

6.1 Fields for PERM+

Appendices A, B, and C list the fields for states to include with the PERM+ data submissions. PERM+ data submissions include provider, recipient, and full claim detail information. States do not need to submit "detail" information after claim sampling. However, this does require the inclusion of more fields in the PERM+ data submission—similar to the field requirements in the routine PERM detail submission.

The data fields to include in each PERM+ file are described in the following appendices:

Appendix A: Claims File

Appendix B: Recipient File

Appendix C: Provider File

6.2 PERM+ Transmission Cover Sheets

Appendix D shows copies of the Transmission Cover Sheets that states should use when submitting files for PERM+. There are separate cover sheets for the claims file, recipient file, and provider file. State should use copies of these transmission cover sheets to report the control totals for each file for each quarter of data submitted for PERM+.

Appendix A: Claims Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
ICN	icn	Unique claim identifier (e.g., ICN, TCN, other state issued number)	X	X	varchar	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
ICN Former	icn_former	For adjustment claims, the state-assigned internal control number (ICN) or transaction control number (TCN) of the claim that the current claim is adjusting	X	X	varchar	

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Claim type	clm_type	State claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim	X	X	varchar	State-specific values
Medicaid/CHIP Indicator	medicaid_chip	Indicator identifying the record refers to a Medicaid (Title XIX) or CHIP (Title XXI) payment.	X	X	numeric	1 - Medicaid (Title XIX) 2 - CHIP (Title XXI)
State Funding Code	state_funding_code	Code that indicates whether the claim is matched with Title XIX, Title XXI, state-only or local funds, or other funding source.	X	X	varchar	State-specific values
Record Type	record_type	Code indicating whether the record is a claim header or a detail/line.	X	X	varchar	'H' – Header Record 'L' – Line Record
Fixed Payment Indicator	fixed_payment_ind	Code indicating whether the claim or payment conforms to the PERM FFS fixed/capitated payment definition.	X		numeric	0 - FFS Claim 1 – Capitated or Fixed Payment

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Adjustment Indicator	adjustment_ind	Code indicating whether the claim/line is an adjustment and the type of adjustment (e.g. original claim, void, credit, debit, etc.	X	X	varchar	State-specific values
Date Paid Header	date_of_payment_header	The date a claim or payment was originally adjudicated or paid; not the check date (unless there is no adjudication date)	X	X	varchar (mm/dd/yyyy)	
Medicare Crossover Indicator Header	mcare_xover_ind_header	Header-level indicator that a claim is a crossover claim from Medicare to Medicaid	X		varchar	"Y"= Crossover "N"= Not a Crossover Ensure all values are coded as "Y" or "N" and the field is populated for all records
Category of Service	service_category	Classification for broad types of state/federal covered services	X		varchar	Can be MSIS category of service or state-defined service type
Source Location	source_location	The system of origin/location in which the claim was originally adjudicated	X	X	varchar	State-specific values

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Payment Status Header	payment_status_header	Paid or denied indicator for a claim as it was originally adjudicated; should not reflect an adjusted payment status	X	X	varchar	State-specific values
Total Computable Amount Paid Header	amt_paid_header	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.) recipient	X	X	Numeric (with decimal)	Ensure the field is not truncated or rounded, and does not contain extra data

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Third Party Liability (TPL) Amount Header	tpl_amt_header	Third Party Liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. This is the total amount denoted at the claim header level paid by the third party.	X		numeric (with decimal)	Ensure the field is not truncated or rounded, and does not contain extra data
Date-of-service From Header	dos_from_header	Beginning date of service on the claim For managed care payments, this field is used to report the beginning date of the coverage period	X	X	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.
Date-of-service To Header	dos_to_header	End date of service on the claim For managed care payments, this field is used to report the end date of the coverage period	X	X	varchar (mm/dd/yyyy)	Ensure end date of service is a valid date, is populated for all records and is after the beginning date of service for the claim.
Recipient ID	recipient_id	Recipient ID number Can be Medicaid ID or system-specific ID	X	X	varchar	This number must match a Recipient ID in the Recipient File

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Billing provider number	billing_prov_id	Billing provider ID number Can be NPI or legacy provider ID	X	X	varchar	This number must match a Provider NPI number or Provider number in the Provider File. If this number does not provide a unique match to correct provider information for the claim in the provider file, please provide additional variables or logic to select correct provider information (i.e., provider location id, etc)
Referring provider number	ref_prov_id	Referring provider number Can be NPI or legacy provider ID	X		varchar	Must be submitted for records billed at the claim line and header level, when available. If this number does not provide a unique match to correct provider information for the claim in the provider file, please provide additional variables or logic to select correct provider information (i.e., provider location id, etc)

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Prescribing provider number	prescribe_prov_id	Prescribing provider number Can be NPI or legacy provider ID	X		varchar	Must be submitted for records billed at the claim line and header level, when available. If this number does not provide a unique match to correct provider information for the claim in the provider file, please provide additional variables or logic to select correct provider information (i.e., provider location id, etc)
ICD procedure code 1	icd_proc_code_1	ICD-9/10 surgical procedure code 1	X		varchar	
ICD procedure code 2	icd_proc_code_2	ICD-9/10 surgical procedure code 2	X		varchar	
ICD procedure code 3	icd_proc_code_3	ICD-9/10 surgical procedure code 3	X		varchar	
ICD procedure code 4	icd_proc_code_4	ICD-9/10 surgical procedure code 4	X		varchar	
ICD procedure code 5	icd_proc_code_5	ICD-9/10 surgical procedure code 5	X		varchar	
ICD procedure code 6	icd_proc_code_6	ICD-9/10 surgical procedure code 6	X		varchar	
Diagnosis 1	diag_code_1	Diagnosis code 1 (primary)	X		varchar	
Diagnosis 2	diag_code_2	Diagnosis code 2	X		varchar	

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Diagnosis 3	diag_code_3	Diagnosis code 3	X		varchar	
Diagnosis 4	diag_code_4	Diagnosis code 4	X		varchar	
Diagnosis 5	diag_code_5	Diagnosis code 5	X		varchar	
Diagnosis 6	diag_code_6	Diagnosis code 6	X		varchar	
Diagnosis 7	diag_code_7	Diagnosis code 7	X		varchar	
Diagnosis 8	diag_code_8	Diagnosis code 8	X		varchar	
Diagnosis 9	diag_code_9	Diagnosis code 9	X		varchar	
DRG	drg_code	Diagnosis Related Group (DRG) code, if applicable	X		varchar	
Line item number	line_item_num	Number denoting individual claim detail/line item	X		numeric (no decimals)	
Line item number former	line_item_num_former	For adjustment claims, number to identify the transaction line number for the claim that the current claim is adjusting	X		numeric (no decimals)	
Date Paid Line	date_of_payment_line	The date a payment line was originally adjudicated or paid	X		varchar (mm/dd/yyyy)	For most claims and payments, this value is the same as Date Paid Header

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Medicare Crossover Indicator Line	mcare_xover_ind_line	Line-level indicator that a claim is a crossover claim from Medicare to Medicaid	X		varchar	"Y"= Crossover "N"= Not a Crossover Ensure all values are coded as "Y" or "N" and the field is populated for all records
Payment Status Line	payment_status_line	Paid or denied indicator for a claim line as it was originally adjudicated; should not reflect an adjusted payment Status	X		varchar	State-specific values
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 all recipient and third party cost sharing (co-payments, TPL, coinsurance, etc.) recipient	X		Numeric (with decimals)	Ensure the field is not truncated or rounded, and does not contain extra data

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Units paid	units_of_svc_paid	Number of units (services) paid	X		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 All paid drug records must have valid units paid greater than 0 If the number of units paid for pharmacy claims are not available, please include quantity dispensed or other relevant information
Third Party Liability (TPL) Amount Line	tpl_amt_line	Third Party Liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. This is the total amount denoted at the claim detail level paid by the third party.	X		numeric (with decimals)	Ensure the field is not truncated, rounded and does not contain extra data

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
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.	X		varchar	
Procedure modifier 1	proc_mod_1	Procedure Code Modifier- 1 on the lines as it was adjudicated	X		varchar	
Procedure modifier 2	proc_mod_2	Procedure Code Modifier – 2 on the line as it was adjudicated	X		varchar	
Procedure modifier 3	proc_mod_3	Procedure Code Modifier – 3 on the line as it was adjudicated	X		varchar	
Procedure modifier 4	proc_mod_4	Procedure Code Modifier – 4 on the line as it was adjudicated	X		varchar	

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
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	X		varchar	
Performing provider number	perf_prov_id	Performing (servicing/ rendering) provider ID number Can be NPI or legacy provider ID	X		varchar	This number must match a Provider NPI number or Provider Number in the Provider File. If this number does not provide a unique match to correct provider information for the claim in the provider file, please provide additional variables or logic to select correct provider information (i.e., provider location id, etc)

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Attending provider number	attend_prov_id	Attending provider ID number Can be NPI or legacy provider ID	X		varchar	This number must match a Provider NPI number or Provider Number in the Provider File. If this number does not provide a unique match to correct provider information for the claim in the provider file, please provide additional variables or logic to select correct provider information (i.e., provider location id, etc)
Date-of-service From Line	dos_from_line	Beginning date of service on the line Should be included for each line of a claim	X		varchar (mm/dd/yyyy)	Ensure beginning date of service is a valid date, is populated for all line level claims, and is prior to the ending date of service for the line claims
Date-of-service To Line	dos_to_line	End date of service on the line Should be included for each line of a claim	X		Varchar (mm/dd/yyyy)	Ensure end date of service is a valid date, is populated for all line level claims and is after the beginning date of service for line claims
Place of service	place_of_svc	Place of service	X		varchar	State-specific values

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Type of service	type_of_svc	Type of service	X		varchar	State-specific values
National Drug Code (NDC)	ndc_code	Made up of labeler(mfr) + product + pkg size configurations	X		varchar	Must be 11 digits including leading and trailing zeroes Ensure this field is populated for ALL pharmacy claims
Drug order date	drug_order_dt	Date drug was prescribed for the pharmacy claim	X		varchar (mm/dd/yyyy)	Ensure this field is populated for ALL pharmacy claims
Prescription number	rx_num	Prescription number for the pharmacy claim	X		varchar	Ensure this field is populated for ALL pharmacy claims
Prior authorization number	prior_auth_num	Prior authorization number	X		varchar	State-specific values
Managed care program indicator	program_indicator	Indicator of the program (TANF, PACE, LTC, Behavioral health)		X	varchar	State-specific values
Payment type	payment_type	Type of managed care payment (e.g., monthly capitation, delivery kick payment or other recipient-specific supplemental payment, individual reinsurance payment)		X	varchar	State-specific values

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Recipient rate indicator	recipient_rate_indicator	Rate cell or rate group used to determine the payment for the recipient to the managed care plan		X	varchar	State-specific values. Please provide data dictionary
Recipient aid category	recipient_aid_category	Aid code used to identify recipient's rate cell and what payment is made to MCO (not the same as eligibility type/group)	X	X	varchar	State-specific values. Please provide data dictionary
ICD Version	ICD_version	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.	X		numeric	Required for all fields where diagnosis codes are populated. "9" ICD-9 "10" ICD-10

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Billed Units of Service	Billed_Units	Used to indicate Units of Service billed if that number is different from the value in the Units Paid field	X		numeric	Required if billed units are different from paid units. In cases where there are fractional units paid, ensure that they are valid and reflect the accurate number of units billed for the corresponding claim

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Bill Type	Bill_type	Also referred to as type of bill. 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.	X		varchar	Required for institutional claims, if available. State specific values.

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Billed Procedure Code	Billed_proc_code	Billed 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. Populate if different than procedure code line on adjudicated version of claim. This may occur automatically in certain state systems where 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.	X		varchar	Required if billed procedure code different from proc_code_line variable.

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
Billed Revenue Code	Billed_rev_code	Billed 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. Populate if different from revenue code on adjudicated version of claim. This may occur automatically in certain state systems where 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.	X		varchar	Required if different from rev_cd.

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
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. Populate if different from adjudicated paid amount on claim.	X		Numeric (with decimal)	Required if amount differs from paid amount on claim. Ensure the field is not truncated or rounded, and does not contain extra data
Federal Claim Category	Federal_Claim_Category	MSIS Code, CMS 64 line, or other state mapping into a federal claim category	X		varchar	Required, if available. State data dictionary required.
Recipient eligibility category	recipient_elig_cat	The specific benefit the recipient qualifies for that is used in adjudication of payment of the claim. This should come from the adjudication system.	X	X	varchar	Provide a data dictionary.

Field Designation	Standard Field Name	Field Description	Required for FFS	Required for MC	Standard Field Format	Quality Review
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 exclude this field, if desired				Optional If state specific values are used, decodes must be provided in data dictionary.
User field 2		Same as above				
User field 3		Same as above				
User field 4		Same as above				
User field 5		Same as above				
User field 6		Same as above				
User field 7		Same as above				
User field 8		Same as above				
User field 9		Same as above				
User field 10		Same as above				

Appendix B: Recipient Fields for PERM+ Data Submissions

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
Recipient ID	recipient_id	Recipient ID number Can be Medicaid ID or system-specific ID	varchar	
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	
Recipient date of birth	recipient_dob	Recipient date of birth	varchar (mm/dd/yyyy)	Ensure year of birth is not future date or extreme date in the past (example: 1800s)
Recipient gender	recipient_gender	Recipient gender code	varchar	Ensure all values are coded as “M” or “F” and the field is populated for all records
Recipient county	recipient_county	Recipient county	varchar	State-specific values
Service area indicator	service_area_ind	Indicator for the geographic service area if the service area is not the county	varchar	State-specific values
Recipient Date of Death	recipient_date_of_death	Date of death of recipient	varchar (mm/dd/yyyy)	

Appendix C: Provider Fields for PERM+ Data Submission

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
Medical Record Contact Name	mr_contact_name	Medical record contact name	varchar	Ensure this field is populated when available Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers
Medical Record Contact Addr 1	mr_contact_addr_1	Medical record contact address first line	varchar	Ensure this field is populated when available Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers
Medical Record Contact Addr 2	mr_contact_addr_2	Medical record contact address second line	varchar	Ensure this field is populated when available Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers
Medical Record Contact City	mr_contact_city	Medical record contact city	varchar	Ensure this field is populated when available Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
Medical Record Contact State	mr_contact_state	Medical record contact state: 2-character postal abbreviation.	varchar	Ensure this field is populated when available Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers Use the abbreviated 2-letter code for each state (e.g. WA for Washington state)
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 when available Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers If possible do not include hyphens when using a ZIP+4 digit code
Medical Record Contact Phone	mr_contact_phone	Medical record contact phone number. All phone numbers should be 10 digits, including the area code	varchar	Ensure this field is populated when available Do not report this field if values are the same as data in the corresponding fields for billing, performing or referring providers

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
Provider number	prov_id	Provider ID Can be NPI or legacy provider ID	varchar	State-specific values Ensure this is a unique identifier match to billing/performing/referring id in claims layout. This ID should guarantee a one-to-one match. If it does not, please include other variables (i.e., provider location ID) or logic to achieve one-to-one match.
Provider name	prov_name	Provider name	varchar	
Provider type	prov_type	Provider type	varchar	State-specific values
Provider specialty	prov_spec	Provider specialty code	varchar	State-specific values
Provider address 1	prov_addr_1	Provider address first line	varchar	
Provider address 2	prov_addr_2	Provider address second line	varchar	
Provider city	prov_city	Provider city	varchar	
Provider state	prov_state	Provider state	varchar	Use the abbreviated 2-letter code for each state (e.g. WA for Washington state)
Provider zip	prov_zip_code	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
Provider phone	prov_phone	Provider phone number(s) All phone numbers should be 10 digits, including the area code	varchar	If possible, do not use hyphens or parentheses
Provider fax	prov_fax	Provider fax number, when available All fax numbers should be 10 digits, including the area code	varchar	If possible, do not use hyphens or parentheses

Field Designation	Standard Field Name	Field Description	Standard Field Format	Quality Review
Provider NPI	prov_npi	Provider NPI, if available	varchar	If certain atypical providers do not have NPIs, please note to SC.

Appendix D: PERM+ Transmission Cover Sheets

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

Transmission Cover Sheet

PERM Plus - Claims 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)								

Transmission Cover Sheet

PERM Plus - Beneficiary File

State:

Date:

Quarter:

Data Descriptions and Control Totals: *Complete the information below for each submitted file. If submitting data documentation, please include a row describing the documentation. Add more rows as necessary. For files containing data, please include the total # of records.*

Data Description (e.g., Q1 Recipient File; data documentation)	**Data Filename**	**File Format** (e.g., text, Excel, SAS)	**File Media** (e.g., CD, DVD, FTP)	**Total # of Records**	**Password Protected? (Y/N)** (if yes, send password separately)
(Add rows if necessary)					

Transmission Cover Sheet

PERM Plus - Provider File

State:

Date:

Quarter:

Data Descriptions and Control Totals: *Complete the information below for each submitted file. If submitting data documentation, please include a row describing the documentation. Add more rows as necessary. For files containing data, please include the total # of records.*

Data Description (e.g., Q1 Provider File; data documentation)	**Data Filename**	**File Format** (e.g., text, Excel, SAS)	**File Media** (e.g., CD, DVD, FTP)	**Total # of Records**	**Password Protected? (Y/N)** (if yes, send password separately)
(Add rows if necessary)					