



Payment Error Rate Measurement Program
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FY 2007

**Payment Error Rate Measurement
Program**

Medicaid and SCHIP

Fee-for-Service and Managed Care Claims

Data Submission Instructions

Release Date: January 10, 2007

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I. INTRODUCTION

A. Purpose

The purpose of the Medicaid Payment Error Rate Measurement (PERM) program is to estimate state-level payment error rates and, from these, national-level payment error rates for Medicaid and the State Children's Health Insurance Program (SCHIP). The error rates will be based on reviews of Medicaid and SCHIP fee-for-service (FFS) and managed care payments made in the fiscal year under review. States will conduct eligibility reviews and report eligibility-related payment error rates also used in the national error rate calculation. See Appendix A for definitions of the terms used throughout this guidance as applied to the PERM program.

The Centers for Medicare & Medicaid Services (CMS) announced in the October 5, 2006 interim final regulation that, in response to public comment, it will adopt a national contracting strategy to measure improper payments in the Medicaid and SCHIP program to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). The national contracting strategy involves three contractors: a statistical contractor (SC), a documentation/database contractor (DDC), and a review contractor (RC). CMS has selected The Lewin Group as the statistical contractor for FFY 2007 PERM, Livanta LLC as the documentation/database contractor for FFY 2007 PERM, and Health Data Insights as the review contractor for FFY 2007 PERM.

As the statistical contractor, Lewin's primary responsibilities are to:

- Sample FFS line items and managed care capitation payments on a quarterly basis, which is done through the following steps:
 - Receive and review the universe of line items/capitation payments from each state,
 - Determine the sample size of line items/capitation payments that will be reviewed for each state,
 - Select a random sample of line items/payments from the universe extract files provided by the state each quarter,
 - Forward the sample selected to the DDC, Livanta LLC.
- Review state eligibility sampling plans and collect eligibility-related error rates from the states. (Note that the eligibility error rate development process is discussed in other documents and is not described in this document.)
- Collect medical review and payment processing error findings from the review contractor for claims/capitation payments.
- Calculate each state's Medicaid and SCHIP program error rates using findings from the medical reviews, processing reviews, and eligibility reviews and calculate national error rates for Medicaid and SCHIP for FY2007 based on the states' error rates.

As the documentation/database contractor, Livanta's primary responsibilities are to:

- Request additional details for the sampled records from the states and compile the claim details into a standardized format,
- Request state Medicaid and SCHIP medical policies from the states,
- Request medical records for sampled fee-for-service paid claims from the providers, and
- Forward the standardized claims details, medical policies, and medical records to the review contractor, HDI.

As the review contractor, HDI's primary responsibilities are to:

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

B. Data Needs of CMS Contractors

The state and the three contractors will work to prepare universe files with Medicaid and SCHIP claims, sample from the universe files, and then gather details on the sampled claims. Below is a brief overview of how each contractor uses the data. See Appendix B for flowcharts of the sampling and review process for FFS claims and managed care payments.

- **Statistical Contractor (SC):** The SC, Lewin, will draw a random sample from the quarterly universe files submitted by the states. For fee-for-service claims, states are asked to provide an extract of the claims record containing the fields listed in Section III.A and in Appendix D. For managed care payments, states are asked to provide all payment details for each capitation payment in the original universe data submission. Additional details on these submissions are provided in Section III.
- **Data Documentation Contractor (DDC):** The DDC, Livanta, is responsible for collecting the information needed by the Review Contractor to accomplish the processing and medical reviews of the samples selected by Lewin.
 - Livanta will request the additional claim and line details for the selected samples and upon receipt of the detail information, compile the data into a standardized format for HDI. The data elements included in this data request will include beneficiary and provider information associated with the sampled claims, as discussed below and in Section IV.
 - Livanta will request the medical records associated with the sampled FFS paid claims. (Medical records will not be requested for denied claims, managed care

claims, Medicare crossover claims, or fee-for-service claims unrelated to a medical record such as a Primary Care Case Management monthly fee.) To request these records, Livanta requires states to provide sufficient information within the sampled claims detail data to permit Livanta to identify the patient and date of service and to contact the servicing and billing providers to request the medical record. The more detail that is provided by the state regarding the billing provider, servicing provider, diagnosis, procedures, and beneficiary, the easier it is for the provider to identify the proper records and return them to Livanta within the 90-day timeframe. Medical records that cannot be obtained from the provider within 90 days are counted as payment errors due to no documentation for PERM purposes. These instructions discuss the required data elements for the sampled claim and line items in more detail in Section IV.

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

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

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

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

II. SAMPLING PROCESS AND TIMELINE

A. Overview of the Sampling Process

Each state submits an extract to Lewin of all beneficiary-specific payments for each of the following four program areas:

- Medicaid FFS
- Medicaid managed care
- SCHIP fee-for-service
- SCHIP managed care

The four extracts must include the required data elements and conform to the specifications in Section III. From each of these program areas, Lewin selects a random sample of claims, line items, or payments from the universe data for the four program areas.

Lewin then forwards these sampled claims to Livanta. Livanta then requests details from the state. The state provides detailed claim and line information for each sampling unit, including adjustments made within 60 days of the original paid date. The state returns the sampling unit details to Livanta, who will standardize the format and return it to the state.

For the managed care samples, the state only needs to return to Livanta any adjustments made within 60 days of the original paid date.

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

The specifications of these universe and sampled claims detail files are described in Appendix D and F below.

1. *Sample Size*

Using the state-supplied universe data, Lewin will draw a random sample of claims and payments for each program. The sample drawn will be of sufficient size to estimate the payment error rate at a precision level of +/- 3 percentage points with 95% confidence. Based on Lewin's FY2006 experience, the quarterly sample for each FFS program will be about 250 payments. Lewin anticipates the quarterly sample for most managed care universes to be about 125 payments. Lewin will establish a sampling procedure for universe files with extremely small numbers of claims.

2. Sampling Steps

The state and Lewin will follow these steps below to select a random sample of payments for further review:

1. Each quarter, the state creates a maximum of four universe files, one for each program area (i.e., Medicaid FFS, Medicaid managed care, SCHIP FFS, and SCHIP managed care). All beneficiary-specific individually-priced services or capitated payments paid with Title XIX and Title XXI funds should be included once, and only once, in one of the four program areas. The payments should be distributed so that each beneficiary-specific payment (including zero-paid items and denied claims) should have one chance of being sampled. *The universe files are due to Lewin 15 days after the end of the federal fiscal quarter.* The FFY 2007 quarter 1 universe data submission, representing claims paid between October 1, 2006 and December 31, 2006, is due to Lewin by January 15, 2007. See Section B, Timeline, below for a detailed timeline.

Note: For FFY 2007, states do not need to stratify their universe files by the MSIS categorizations.

2. Upon receipt of the state's universe files, Lewin will review the state's Universe Data Transmission Cover Sheet (included in Appendix E) and conduct quality control checks to ensure that universe files are readable and formatted appropriately, and that each universe includes the required fields described in Section III and Appendix D. Lewin will follow up with the state about any weaknesses in the data.
3. Once the universe passes quality control checks, Lewin will select a sample of payments from each program area universe. Lewin will select payments at the lowest separately priced unit available, which is generally the line item in the FFS universes and the monthly capitation payment or kick payment in managed care universes. Lewin will conduct statistical tests to ensure that the sample is random and representative of the universe. If there are no problems identified through the quality control checks, Lewin will select the samples within about 30 days of receiving the universe files from the state. Lewin will send the sample to Livanta by February 15 if there are no weaknesses in the universe data.
4. Livanta will forward the sample to the state.
5. For FFS data, the states then pull the claim header information and line details for each sampling unit and any adjustments made within 60 days of the original payment date. The state returns the sampled claims details to Livanta. For managed care data, the state will return to Livanta any adjustments made within 60 days of the original payment date on each claim. *States are asked to provide the detailed FFS claims records and adjustments to FFS and managed care adjustments within two weeks of receipt of the sample.*
6. Livanta will then conduct quality control checks of the detailed data and, if it meets the requirements included in these instructions, Livanta will standardize the format (if not provided in the standard format by the state) and transmit the information to HDI.

7. The state will receive a copy of the standardized claims data file from Livanta as transmitted to HDI.

If problems are identified during any step of the process, Lewin or Livanta will contact the state via email, with a follow-up by phone if necessary. States are asked to please respond to inquiries about the data within two days of Lewin or Livanta’s contact and provide additional or replacement data within five days of request.

The state is responsible for submitting detailed claim and line data that meet all of the requirements described in Appendix F. The state may submit the sampled claims and lines in the standardized format provided by Livanta, or in consistent state format that meets the requirements. Livanta will conduct quality control checks on the data. If problems are identified during any step of obtaining claim and line details from the state, Livanta will contact the state directly to resolve the situation.

B. Timeline

To select a random sample of payments for review, Lewin will need to obtain claims and capitation payment data from each state on a quarterly basis, within 15 days of the end of the quarter. The entire PERM project cycle is expected to take approximately two years, with the sampling activities concentrated in the first four quarters and the error rate calculation occurring at the end of the review cycle.

Timeline of State Data Transfers		
Quarter 1		
January 16, 2007	Universe data submission by state	State submits PERM-compliant Q1 (October 1-December 31, 2006) FFS and managed care payment universes for Medicaid and SCHIP to Lewin
February 15, 2007	Lewin selects sample and sends to Livanta; Livanta sends sample to the state	Lewin selects FFS and managed care samples for Medicaid and SCHIP Livanta forwards Q1 samples to state for details and adjustments
March 2007	Sampled claim detail and adjustments submission by state	State returns FFS details and FFS and managed care adjustments on Q1 samples to Livanta
Quarter 2		
April 16, 2007	Universe data submission by state	State submits PERM-compliant Q2 (January 1 –March 31, 2007) FFS and managed care payment universes for Medicaid and SCHIP to Lewin
May 15, 2007	Lewin selects sample and sends to Livanta;	Lewin selects FFS and managed care samples for Medicaid and SCHIP

Timeline of State Data Transfers		
	Livanta sends sample to the state	Livanta forwards Q2 samples to state for details and adjustments
June 2007	Sampled claim detail and adjustments submission by state	State returns FFS details and FFS and managed care adjustments on Q2 samples to Livanta
Quarter 3		
July 16, 2007	Universe data submission by state	State submits PERM-compliant Q3 (April 1 - June 30, 2007) FFS and managed care payment universes for Medicaid and SCHIP to Lewin
August 15, 2007	Lewin selects sample and sends to Livanta; Livanta sends sample to the state	Lewin selects FFS and managed care samples for Medicaid and SCHIP Livanta forwards Q3 samples to state for details and adjustments
September 2007	Sampled claim detail and adjustments submission by state	State returns FFS details and FFS and managed care adjustments on Q3 samples to Livanta
Quarter 4		
October 15, 2007	Universe data submission by state	State submits PERM-compliant Q4 (July 1 - September 30, 2007) FFS and managed care payment universes for Medicaid and SCHIP to Lewin
November 15, 2007	Lewin selects sample and sends to Livanta; Livanta sends sample to the state	Lewin selects FFS and managed care samples for Medicaid and SCHIP Livanta forwards Q4 samples to state for details and adjustments
December 2007	Sampled claim detail and adjustments submission by state	State returns FFS details and FFS and managed care adjustments on Q4 samples to Livanta

III. UNIVERSE DATA REQUIREMENTS FOR STATISTICAL CONTRACTOR

This section discusses the fee-for-service and managed care data submission requirements for the universe files. Each quarter, the states will send Lewin universe files for Medicaid FFS, SCHIP FFS, Medicaid managed care, and SCHIP managed care. Lewin will select samples from these universe files and send the samples to Livanta. Part A, below, reviews instructions specific to the Medicaid and SCHIP FFS universe files. Part B then discusses the Medicaid and SCHIP managed care universe files. Part C discusses data submission to Lewin for both the FFS and managed care universe files.

A. Universe – Medicaid and SCHIP FFS

The universe data contains all fully adjudicated FFS claims or line items; however, the universe data is an extract containing only a small number of data elements or fields. States will transfer data containing all fully adjudicated Medicaid and SCHIP FFS claims, including adjudicated denials, on a quarterly basis, for the each of the four quarters of FY 2007. States will include claims in the quarterly sample based on the **original date of payment** or, for denied claims, payment or adjudication date.

1. *Payments To Be Included*

The FFY2007 FFS universe consists of all adjudicated FFS claims or line items which were originally paid (paid claims) or for which payment was requested but denied (denied claims) from October 1, 2006 through and including September 30, 2007, *and* for which there is federal financial participation (FFP) (or would have been if the claim had not been denied) through Title XIX (Medicaid) or Title XXI (SCHIP).

For Medicaid, all health care 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, are included in the Medicaid FFS universe. Payments for which the state received federal match for administrative services are not included. *State-only services and services provided with financial funds from other federal programs but without Title XIX FFP dollars are not included in the Medicaid universe, regardless of whether such payments are processed through a Medicaid claims processing system.*

For SCHIP, all health service payments that are paid for in whole or in part by Title XXI FFP dollars, as well as claims submitted as Title XXI services but denied, are included in the SCHIP FFS universe. *State-only services that are processed through an SCHIP system but for which Title XXI funds are not sought are excluded.*

When states divide FFS claims between the Medicaid and SCHIP universes, claims should be categorized based on the federal money source, not the program design. *Therefore, payments for Medicaid expansion-type SCHIP programs or Medicaid expansion groups, which are matched by Title XXI FFP, are included in the SCHIP universe.* States which have both a FFS Medicaid-expansion type SCHIP program and a stand-alone FFS SCHIP program must combine the claims for these Title XXI programs into a single SCHIP universe.

For purposes of the PERM program, the FFS universe includes, in addition to regular claims payments, fixed payments made on behalf of beneficiaries, including Medicare Part A and Part B premiums made on behalf of Medicaid beneficiaries and primary care case management (PCCM) payments. Health Insurance Premium Programs (HIPP), which pay for private health insurance premiums when it is more cost-effective than providing full Medicaid/SCHIP coverage, are also included in the relevant Medicaid or SCHIP universe, if applicable.

Note that the following types of payments are excluded from the Medicaid and SCHIP PERM universe files:

- All payments not associated with an individual;
- State-only funded services or services not matched with Title XIX or Title XXI funds;
- Disproportionate Share Hospital (DSH) payments;
- Adjustment records including credit claims and replacement claims;
- Gross adjustments which cannot be tied to individual claims;
- Grants to state agencies, local health departments, and non-profit providers for services not tied to individual beneficiaries;
- Drug rebate reconciliations; and
- Costs for program administration.

2. Claim or “Sampling Unit”

The universe file will have one record for each sampling unit, defined as a line item, fixed payment, or individually priced service tied to a single beneficiary. **States must provide universe data at the sampling unit level.** In discussion, the term “claim” is often used throughout this document to refer to the sampling unit, but the relevant unit may be at the claim header level as with many institutional claims and fixed payments, or at the line item level, as with services priced at a procedure code level.

For example, for those states that use a prospective payment or diagnosis-related groups (DRG) system for inpatient stays, the smallest independently priced item is the DRG itself. In this case, the DRG (or claim header) is the sampling unit. In this example, the universe file would include a single record for these inpatient hospital claims, with the amount paid equal to the amount paid for the entire claim. The state would not include records for the detail lines associated with the header in the universe file. Similarly, if the inpatient stay is priced as an all-inclusive per diem payment amount, the sampling unit would be at the claim header level.

Most physician claims are paid by individually-priced procedure codes recorded at the line or detail level. The state would submit the physician claims in the universe file at the line level, with each record or sampling unit representing a claim detail and the amount paid for that detail. For a lab claim with several separately priced tests, each line item on the claim would be defined as a sampling unit and sampled separately. A claim for lab tests paid on a bundled basis would be treated as a single sampling unit.

Note: In no case can a sampling unit be represented multiple times within a universe file, or included in more than one universe file across programs or across quarters. 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.

3. Paid Amount

Only original paid claims and denied claims are to be included in the universe. Paid amount, for sampling purposes, is defined as the **original amount paid** for the individual sampling unit. Information on adjustments made within 60 days of the original date of payment will be requested after the sample is selected. Adjustment records including credit claims and replacement claims must be excluded from the universe.

The universe includes zero-paid claims and line items (i.e., a valid claim that the state had no financial liability due to, for example, third party liability or a Medicare payment exceeding the state allowable charge).

The paid amount provided with each sampling unit must be the amount corresponding to that sampling unit, whether it is the amount paid for an admission in the case of DRG claims, or the amount paid for an individual line item.

4. Paid Date

Sampling units are selected for inclusion in each quarter's data only if the original date of payment or adjudication (for denied claims) falls within the quarter, regardless of the date of any subsequent adjustments. See Appendix C for an illustration of the selection criteria for paid/adjudication date and paid amount.

5. Payment Status

States must distinguish denied claims from paid claims in the universe. Lewin will sample denials differently from paid claims.

Denied claims/line items include any claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and rejected for payment. If the sampling unit is at the line item level and the line item is denied but other line items are paid, the line item is considered a denial and the other line items are considered paid. Denials do not include claims submitted by providers but rejected from the claims processing system prior to adjudication. Please contact Lewin if you have specific questions about how denials should be defined within the constraints of your processing system.

6. Claim Type

In the universe data, states must also include a claim type identifier to distinguish between claims types such as inpatient, outpatient, professional, prescription, Medicare crossover, etc. The state will provide a data dictionary for the state-defined identifiers.

Note: For FFY 2007, states do not need to stratify claims by MSIS categorizations.

7. Other Beneficiary-specific Payments

Although most non-claims-based sampling units are excluded from the universe, states should include Medicare Part A, Part B, and Part C (Medicare Advantage) premiums in the FFS universe. Since many states pay these premiums on an invoice basis rather than a claims basis, it may be necessary to create “dummy claims” in order to sample individual premium payments. The FFS detail information in Appendix F notes if the field is required for dummy claims.

Likewise, the state must include a separate claim record (a “dummy claim”) for each beneficiary for every monthly PCCM and HIPP payment, regardless of whether a single consolidated payment is made to a primary care PCCM provider or HIPP insurer. States should also include fixed monthly service payments to a fiscal intermediary for consumer-directed (individualized budgeted) services.

Also, sampling units which are not defined as managed care but which reflect payments made on a capitated basis should be identified and included, regardless of whether a service was received by the beneficiary within the service period. For example, a state may contract with a taxicab company to provide non-emergency transportation services for children with special health care needs in the company’s service area.

When submitting “dummy claims” in the universe files to Lewin, be sure the dummy claims contain:

- A unique “claim” identifier. Each sampling unit must be at the beneficiary and service month level and have a unique “claim” identifier (similar to an ICN) that is not duplicated within or across universe files. For example, the state may be able to create a “claim ICN” by combining the client ID or SSN, date of payment, date of service, and amount paid. Due to retrospective premium payments, combining only client ID, date of payment, and amount paid does not lead to a unique identifier. States should be sure to verify that their methodology leads to a unique ID that will allow the state and HDI to identify supporting information relating to that specific payment;
- The sampling unit would be at the claim header level; typically there would be no line item detail in the full claim data;
- The amount paid is generally the monthly capitation amount per beneficiary;
- The state should create separate claim types for each of the different types of dummy claims (e.g., distinguish between the Medicare A premiums, Medicare B premiums, and HIPP payments) and include the claim types with the data dictionary; and
- The service dates would reflect the month for which the payment was made.

8. Required Fields for FFS Universe Data Submission

The states must include at least the following fields in each FFS universe file¹. The universe file should contain a value for each of these required fields for every claim or line item. The state must submit the universe file with a single fixed record length and fixed record format. See Appendix D for details of each field.

- Unique claim ICN (for those cases where dummy claims need to be created (e.g., Medicare premium payments), be sure to create a unique ICN that ties back to an individual client, payment type, payment date, and date of service; no ICN and line number combination can appear in the universe file more than once). When combining data from various claim processing or data base systems, first validate that the claim identifiers will remain unique when combined within the universe file;
- Line item number (can be filled with “0” if sampling unit is at the header level);
- Date of original payment;
- Paid amount (original payment only – adjustments to the paid amount made within 60 days of original payment date will be requested after the sample is drawn; \$0 for denied claims);
- Provider type, or similar variable;
- Claim type;
- Claim status (paid or denied).

9. Summary of Data Requirements – Medicaid and SCHIP FFS Universe

Below is a summary of the data requirements for the FFS universes for Medicaid and SCHIP. The state is responsible for ensuring that universe data submitted meets all of the requirements described in this chapter and summarized below. Part C of this section discusses details for transmitting the universe data to Lewin and suggestions for quality control steps the state should take to ensure that the data comply with the requirements.

- For Medicaid, include in the Medicaid FFS universe all fully-adjudicated fee-for-service claims or line items that are paid for in whole or in part by Title XIX federal financial participation (FFP) dollars, even if the payments are not made through the claims system (e.g., Medicare premiums) or are made by other agencies within the state;
- For SCHIP, include in the SCHIP FFS universe all fee-for-service claims or line items that are paid for in whole or in part by Title XXI federal financial participation (FFP) dollars, even if the payments are not made through the claims system or are made by other agencies within the state;

¹ The state may include additional fields if they may be helpful in sampling the data. Data definitions, field codes, and crosswalks should be included for all fields provided in the extract.

-
- Include claims or line items which were paid (paid claims), including zero paid claims, or for which payment was requested, adjudicated, but denied (denied claims);
 - Include only payments (paid and denied claims) with an original paid or adjudicated date within the sampled quarter;
 - Include the original paid amount (adjustments for claims or lines will be requested after the sample is drawn);
 - Include data at the smallest independently priced item level (i.e., each record in the data file must represent a single sampling unit), with individual identifiers (line item number or claim number and line identifier);
 - Sampling units must be tied to a single beneficiary; gross adjustments are not included;
 - Payments for individual beneficiaries made on a consolidated basis to a single provider (e.g., a single monthly PCCM payment covering multiple beneficiaries assigned to a primary care provider) must be broken down into individual sampling units in the universe;
 - The amount paid in each record must reflect the payment for the sampling unit – the amount paid for the specific line item for line item level units, or the amount paid at the claim header level for claim-level sampling units;
 - The state must include a claim type for all sampling units.

B. Universe– Medicaid and SCHIP Managed Care

This section discusses the managed care data submission requirements for the universe files. Each quarter, the states will send Lewin universe files for Medicaid managed care and SCHIP managed care payments. Lewin will select samples from these universe files.

States will transfer data containing all adjudicated Medicaid and SCHIP managed care payments on a quarterly basis for the each of the four quarters of FY 2007. States will include payments in the quarterly sample based on the original date of payment or, for denied payments, adjudication date.

1. Distinguishing Managed Care from Fee-for-Service

Generally, payments should be included in the managed care universe if the managed care provider assumes full or partial risk for the cost of health care services included in the managed care program. However, if a managed care organization is paid prospectively for health care costs on a capitated basis, but the state later undertakes a cost reconciliation process for actual costs incurred by the organization following the end of the contract period, these claims should also be treated as managed care. This approach relates to those programs for which cost reconciliation is accomplished well after the period of service delivery.)

Some Medicaid and SCHIP programs purchase full-risk indemnity (FFS) coverage for enrollees, usually because of a lack of managed care options. If the insurer is at risk for coverage of a

certain benefit package, the premiums should be treated as capitation payments for the purpose of inclusion in the PERM managed care universe.

Specialty managed care programs for which the capitated provider is at risk (e.g., PACE programs, capitated behavioral health managed care programs) are included in the PERM managed care universe.

If the state pays a network access fee or a management fee to a managed care organization, and then reimburses the managed care organization for each encounter, these encounter payments are in the FFS universe. (Management fees for which the state seeks federal financial participation on an administrative cost basis are excluded from the PERM program.)

Lewin recognizes that there is great variety in states' managed care models and provider reimbursement methods. Contact Lewin to discuss your specific programs if you need additional clarification.

2. Payments To Be Included

The managed care universe consists of all adjudicated managed care capitation payments or associated payments which were originally paid or for which payment was requested but denied (denied payments) from October 1, 2006 through and including September 30, 2007, and for which there is FFP through Title XIX (Medicaid) or Title XXI (SCHIP).

For Medicaid, all managed care payments that are paid for in whole or in part by Title XIX federal financial participation (FFP) dollars are included in the Medicaid universe (state-only and Title XXI services that are processed through a Medicaid system are excluded).

For SCHIP, all managed care payments that are paid for in whole or in part by Title XXI FFP dollars are included in the SCHIP universe (state-only services that are processed through an SCHIP system are excluded). Note that payments for Medicaid expansion-type SCHIP programs or Medicaid expansion groups, which are matched by Title XXI FFP, are included in the SCHIP universe. When states have a single managed care program serving both Medicaid and SCHIP populations, the capitation payments must be separated into the Medicaid and SCHIP universes based on the federal program providing the match.

The managed care universe includes, in addition to regular capitation payments, special payments made to managed care plans on behalf of individual managed care enrollees. These may include maternity "kick" payments or other supplemental payments and individual reinsurance or stop-loss payments.

Note that, for PERM purposes, the following types of payments are included in the FFS universes (not the managed care universes):

- Primary care case management (PCCM) payments;
- Payments made to managed care organizations through Health Insurance Premium Payment (HIPP) programs;

-
- Medicare premium payments for Medicare Advantage plans;
 - Other management fees or access fees paid with Medicaid or SCHIP service funds;
 - Fee-for-service payments for benefits carved out of a managed care program;
 - Services reimbursed on a non-risk capitated basis or case rate basis which are later cost reconciled. See Section III Part A for the FFS data requirements.

3. Paid Amount

Paid amount, for sampling purposes, is defined as the original amount paid for each beneficiary-specific payment. (That is, even if a managed care organization receives a single payment each month for all enrolled beneficiaries, the paid amount for PERM purposes will be the capitation amount for each enrolled beneficiary.)

Some states have “zero paid” and “denied” payments for the managed care universe. Therefore, Lewin will need a paid or denied indicator in the managed care universe files.

Information on adjustments made within 60 days of original date of payment will be requested by Livanta after the sample is selected. Do not include adjustments in the universe.

4. Paid Date

Include payments in each quarter’s data only if the original payment date falls within the quarter.

Managed care capitation payments are often made 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). For PERM purposes, payments should be included in the quarter according to the date the payment was actually made, not the date or period for which the coverage was purchased.

Adjustments made within the quarter must be excluded from the universe. They will be requested by Livanta after the sample is drawn.

See Appendix C for an illustration of the selection criteria for paid date and amount paid.

5. Sampling Unit

The sampling unit is a capitation payment or individual payment tied to a single beneficiary. States must provide universe data at the sampling unit level. For most payments in the managed care universe, the sampling unit is the monthly capitation payment made for each enrolled beneficiary. Other individual payments such as kick payments or individual stop-loss payments would also be treated as individual sampling units.

6. Required Fields for the Managed Care Universe Data Submission

In the universe, states should include at least the following fields for each unique payment record:

- Unique Record ID (ICN)
- Date paid
- Paid amount
- Managed care program indicator
- Type of payment (e.g. monthly capitation, delivery kick payment, individual reinsurance payment)
- Provider ID (Managed Care Organization)
- Recipient ID
- Recipient Name
- Recipient rate indicator (“procedure code” or other rate cohort indicator)
- Recipient-specific information placing the individual in the rate cohort such as:
 - Date of birth
 - Gender
 - County
 - Service area indicator
 - Aid category
 - Diagnosis
 - Risk score (if applicable for rate determination)
- Coverage period (month or from and to dates)
- Paid or denied indicator
- Adjustment indicator

Note that Lewin, the state, and the other CMS contractors must be able to identify each unique payment. Recipient ID number will not be sufficient to identify a unique payment, as the same ID may be used in multiple months during the quarter. If the state’s payment system does not assign a unique recipient-level and payment-level specific identification number to each payment, the state must develop and add to the universe data some sort of identifier unique to each sampling unit before submission for PERM purposes.

7. Summary

Below is a summary of the highlights of the data requirements for the managed care universes for Medicaid and SCHIP. Part C below includes details for transmitting the universe data to Lewin for sampling, including suggestions for quality control steps the state should take to ensure that these data requirements are followed. While Lewin will also conduct quality control

checks, the state is responsible for submitting universe data that meets all of the requirements described in this chapter and summarized below.

- Include in the Medicaid universe all managed care payments that are paid for in whole or in part by Title XIX FFP dollars;
- Include in the SCHIP universe all managed care payments that are paid for in whole or in part by Title XXI FFP dollars;
- Include only payments with an original paid date within the relevant quarter being sampled;
- Include the original amount paid (adjustments will be requested after the sample is drawn);
- Sampling unit is the smallest independently priced item and will generally be the beneficiary-specific capitation payment or special payment made on behalf of an individual;
- States must provide data at the sampling unit level, with each record (sampling unit) having a unique claim identifier; and
- Sampling units must be tied to a single beneficiary – consolidated payments for multiple beneficiaries must be broken down into sampling units.

C. Universe Data Transmission Instructions

The section describes the universe data submission media, discusses the universe data submission formats, recommends minimum data quality control checks, and explains the Data Transmission Cover Sheet to accompany state submissions of universe data.

1. Data Submission Media

Lewin's data systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, cartridge tapes, portable hard drives). Lewin expects most states will send their data on CDs. States should submit two copies of each submission media (e.g., send two copies of each CD), one labeled "original" and one labeled "duplicate."

For details on data security, passwords, and encryption, see Section V.

2. Data Submission Formats

The state will provide Lewin with one file of all adjudicated claims and denials for each of the program areas -- Medicaid FFS, Medicaid Managed Care, SCHIP FFS, and SCHIP Managed Care. Each state will submit a maximum of four files per quarter (although Lewin will accept a program-specific separate "dummy claim" universe file upon state request) by the 15th day of the month following the end of the quarter.

States must provide universe data in a universal text format data (also called "flat format" or "ASCII format") with a single fixed record length and layout. Lewin will process flat file data on an IBM mainframe or SAS server, depending on the size of the data. If your state uses a

system compatible with Lewin's (e.g., PC-based SAS server and IBM mainframe), you may send claims data in a PC-based SAS dataset upon receiving confirmation of system compatibility. In fact, files in the MS Windows version of SAS are preferred.

For the universe data, Lewin will not provide states with a specific record layout. However, each data submission must be accompanied by a detailed record layout. This layout may be in a flat text file, MS Windows SAS format, or parsed and fully labeled in an Excel spreadsheet. *Except for the first row of the field names, please do not include any log or summary information at the beginning or the bottom of the data file.* States must provide the definitions for any fields with state-defined codes (e.g., provider type, claim status, managed care program identifier).

3. Quality Control

States must perform a quality control check on the universe prior to submitting the data to Lewin. If the state does not perform a quality control check on the data, the state is likely to expend additional time and expense identifying and correcting errors in the data, which results in the state falling behind schedule in its measurement under PERM. Therefore, states should validate (quality control) each dataset prior to submitting the data to Lewin. States must also include control totals for each dataset on the Data Transmission Cover Sheet.

Listed below are minimal actions that Lewin recommends the state undertake to conduct a quality control check on its data.

a) Universe Quality Control – FFS

- ✓ Data include the appropriate universe (divided between Title XIX and Title XXI and between fee-for-service and managed care as defined in this document).
- ✓ Each payment is represented in only one universe, and only once in each universe.
- ✓ Only payments with an original paid date within the quarter are included.
- ✓ Each ICN/unique claim/line identifier is unique at the sampling unit level.
- ✓ Each claim is assigned a state-defined claim type and a claim status.
- ✓ Data contain Medicare Premium payments.
- ✓ Data contain HIPP and PCCM payments, if applicable.
- ✓ Records reflect the smallest independently priced service level, which may be a capitation payment or fixed payment.
- ✓ All claims reflect original paid amounts prior to adjustments.
- ✓ All required fields are included on each claim.
- ✓ Data are in a universal text format or SAS format.
- ✓ Record layouts are included in a separate file.

b) Universe Quality Control – Managed Care

- ✓ Data include the appropriate universe (divided between Title XIX and Title XXI and between fee-for-service and managed care as defined in this document).
- ✓ Each payment is represented in only one universe, and only once in each universe.
- ✓ Only payments with an original paid date within the quarter are included.
- ✓ Each ICN/claim identifier is unique to the sampling unit.
- ✓ Kick payments for deliveries and other non-capitation managed care payments are included in the universe (if applicable).
- ✓ All claims reflect original paid amounts prior to adjustments.
- ✓ All required fields are included on each claim.
- ✓ Data are in a universal text format or SAS format.
- ✓ Record layouts are included in a separate file.

4. Timelines for Transmission – Universe Files

Universe data must be received by Lewin by the 15th of the month following the end of each quarter in FFY2007 or, if this date coincides with a federal holiday or weekend day, the following business day. The schedule for submissions is provided below.

Quarter	Last Day of Quarter	Date Lewin Will Request Universe Data	Date Lewin Must Receive Universe Data
Quarter 1	December 31, 2006	December 20, 2006	January 16, 2007
Quarter 2	March 31, 2007	March 20, 2007	April 16, 2007
Quarter 3	June 30, 2007	June 20, 2007	July 16, 2007
Quarter 4	September 30, 2007	September 20, 2007	October 15, 2007

5. Transmission Information

Due to the large number of quarterly universe files Lewin receives from the states, *Lewin asks that the state submit a Universe Data Transmission Cover Sheet with every data submission.* The Data Transmission Cover Sheet is included in Appendix E and, for your convenience, is also provided in a separate Microsoft Word document. Please include the data transmission cover sheet (without passwords) with any mailed data, and also email a copy to us (permisc.2007@lewin.com) the day the data is sent.

6. Lewin’s Mailing Address

Mail universe data files to Lewin at:

Payment Error Rate Measurement Program, c/o Moira Forbes
The Lewin Group
3130 Fairview Park Drive
Suite 800
Falls Church, VA 22042

IV. CLAIM AND LINE DETAILS DATA REQUIREMENTS FOR DOCUMENTATION / DATABASE CONTRACTOR

A. Sample Detailed Claims Data – Medicaid and SCHIP FFS

As described in Section II, for the Medicaid and SCHIP FFS universes, states will submit only an extract of the claims information for all adjudicated sampling units (paid claims and denials) for each quarter. From the universe claims extract, Lewin will select a random sample and send the list of selected claims/line items to Livanta. Livanta will request details from the states.

1. Information To Include in the Sampled Claim Details Data

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

- Complete claim information: This includes both header-level information and information on all details or lines associated with the claim of the sampled unit. For example, if line 2 of a claim is sampled, the information returned by the state should include information from the header and data on all lines associated with that claim header (not just the sampled line). Likewise, if the sampling unit is sampled at the claim header level, all lines associated with that claim header must be returned by the state.
- Claim history: The sampled unit plus any adjustments made within 60 days of the original paid date (see the next section for details); and
- Complete details for all returned FFS claims: Claim details will include fields necessary for Livanta to request a medical record and for HDI to conduct a processing and medical record review. Livanta has developed two lists of required fields for FFS sampled claims: (1) a list of required fields for most services paid in your claims processing system (e.g., health services) and (2) a list of required fields for “dummy claims” representing premium payments and other capitated, non-managed care claims that are tied to a specific beneficiary yet are not service specific. See Appendix F for required field details.

Sampled Claims Details, Required Fields: “Dummy claims”

States should include Medicare premium payments and potentially other payments for Medicaid and SCHIP beneficiaries (e.g., PCCM, HIPP) that are not necessarily captured in the MMIS in claim format. In the case of Medicare premium payments, states should submit “claim” records including the beneficiary information (ID number, name, demographics, aid category, payment amount), a code indicating the nature of the benefit or service for which payment is rendered (e.g., HIPP, Medicare Part B, etc.), the date of payment, and the “service” date or time period for which payment is being made. See Appendix F for a detailed list of required fields.

Each state may have different information available for this type of claim. Livanta will work with each state individually to answer any questions and identify a workable method for providing the necessary data.

For all states, complete claim and line details for each sampling unit *should be returned to Livanta within two weeks of receipt of the sample* by the state. Part C of this Section includes details for transmitting the sample data to Livanta, including suggestions for quality control steps the state should take to ensure that these data requirements are followed.

2. Adjustments

The PERM August 28, 2006 interim final regulation requires that adjustments made within 60 days of the original paid date be considered in the review process. The CMS contractors will consider the net amount paid (original paid amount with additions/subtractions due to adjustments that occurred within 60 days) in calculating the error rate.

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

Livanta understands that different Medicaid Management Information Systems maintain different levels of historic detail on adjustments and will work with states to identify mechanisms and data fields to appropriately account for adjustments.

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

B. Sample Medicaid and SCHIP Managed Care

1. Details

When submitting the managed care universe, states will be asked to submit complete payment information for all adjudicated sampling units for the managed care universes for each quarter, with all fields necessary for HDI to conduct a processing review. Lewin will select a random sample by month and send the list of selected payments to Livanta, who will then ask the states to return the adjustments within two weeks of receiving the sample from Livanta. For all sampled managed care payments, the state will return only adjustments made within 60 days of the original paid date.

2. Adjustments

The PERM August 28, 2006 interim final regulation requires that adjustments made within 60 days of the original paid date be included in the review process, which will consider the net amount paid (original paid amount with additions/subtractions due to adjustments that occurred within 60 days) in calculating the error rate.

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

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

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

C. Sample Data Transmission Instructions

1. Data Submission Media

Livanta will accept details on sampled claims on CDs and DVDs, appropriately labeled. (See Section V, Data Security.)

2. Data Submission Formats

The state may submit the claims and lines in the standardized format provided by Livanta, or in a consistent state format that meets the requirements. (See Appendix F.)

3. Quality Control

a) Sample Quality Control – FFS

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

b) Managed Care Adjustments to Sampled Payments

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

4. Transmission Information

Prior to the initial claims submission, Livanta will collect state data dictionaries and decode values for requested data elements. For example, if the state uses local provider type codes,

Livanta will request the state provide the provider type definitions associated with the codes. Additionally, if the state's ICN or TCN has imbedded logic (e.g., the first two digits reflect claim submission media), Livanta will request the state submit the ICN logic.

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

5. Livanta's Mailing Address

Address Information for Claims Details Submission:

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

E-mail Address: papplegate@livanta.com

V. DATA SECURITY

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

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

States should send electronic media via a private overnight delivery service (such as FedEx or UPS) or USPS and mark "To be opened by addressee only." Data containing electronic personal health information (EPHI) should not be e-mailed. Passwords and data documentation including file names, record layouts, and data definitions should be sent to Livanta by mail or email. *Password information must be sent separately from the data.*

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

APPENDIX A

Definitions

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

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

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

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

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

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

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

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

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

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

APPENDIX A

Definitions

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

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

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

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

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

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

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

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

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

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

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

Primary Care Case Management (PCCM): A program in which beneficiaries are linked to a primary care provider who coordinates their health care. Providers receive small additional

APPENDIX A

Definitions

payments to compensate for care management responsibilities, typically on a per member per month basis. Providers are not at financial risk for the services they provide or authorize.

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

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

Stop-loss: See "Individual Reinsurance," above.

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

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

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

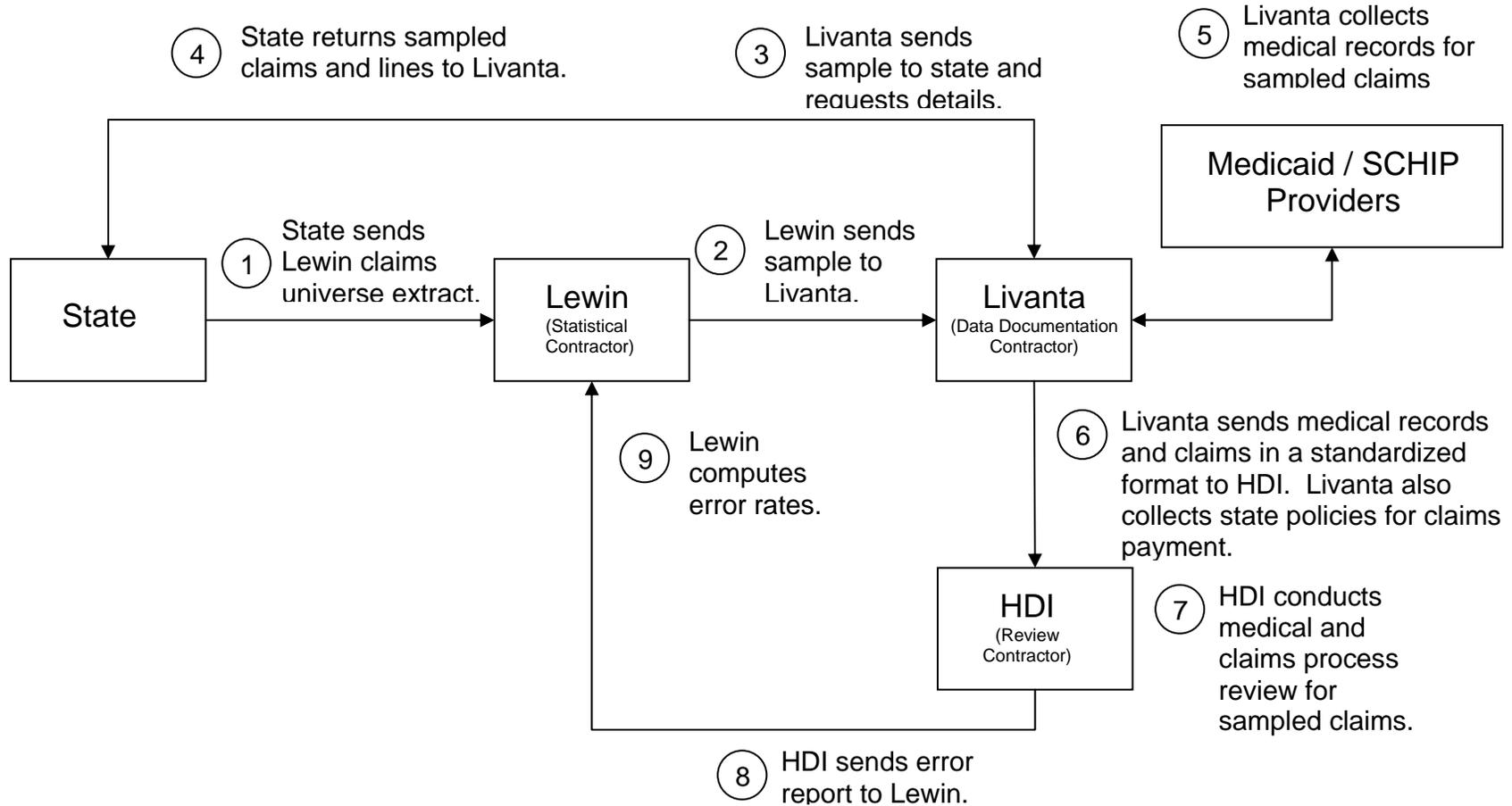
Universe: The universe is the set of sampling units from which the sample for a particular program area is drawn and the set of payments for which the error rate is inferred from the sample. The term "claim" is used interchangeably with the term "sampling unit."

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

APPENDIX B

Process Flowcharts of the Sampling and Review Process

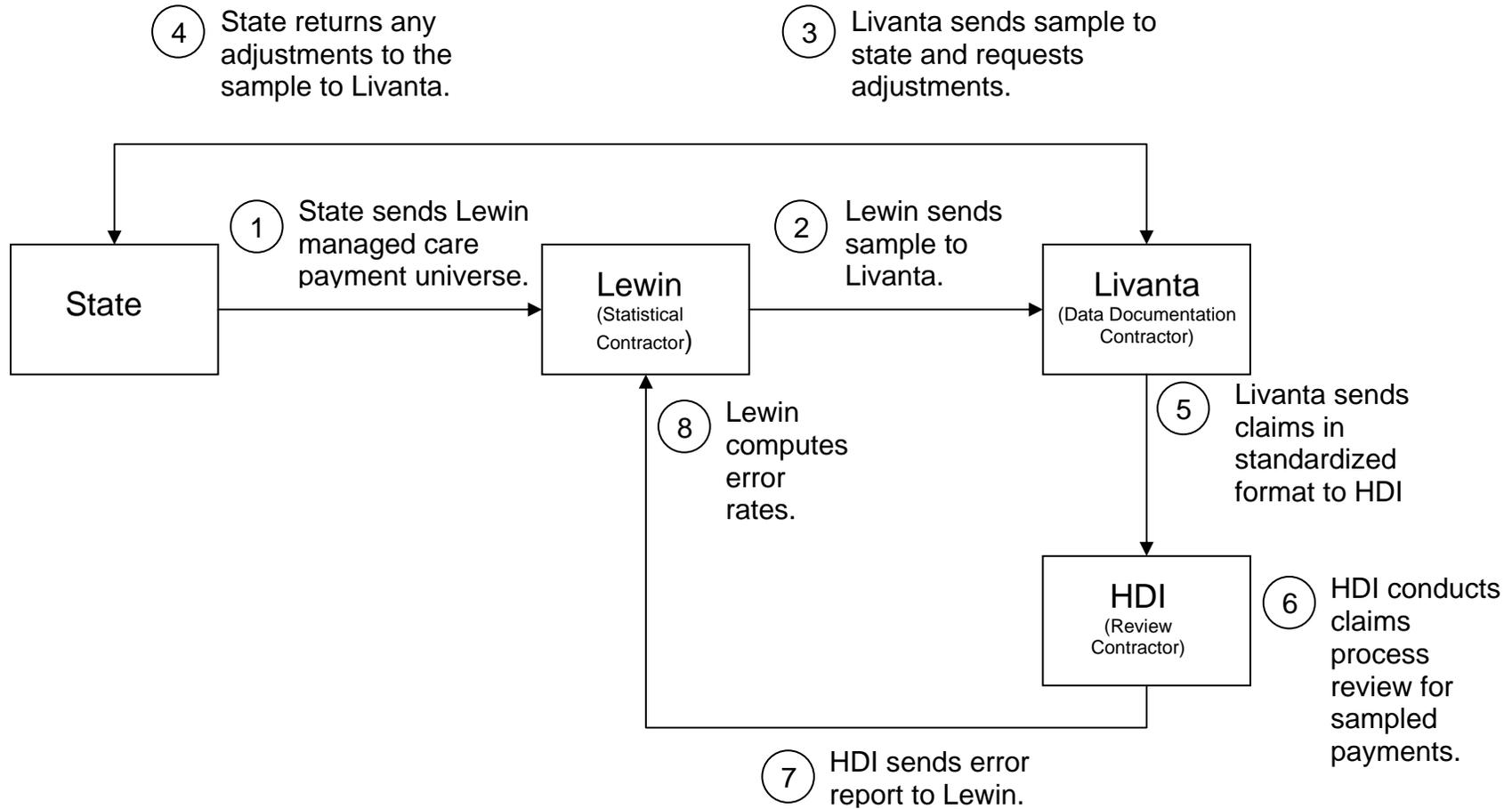
Medicaid FFS and SCHIP FFS claims sampling and review



APPENDIX B

Process Flowcharts of the Sampling and Review Process

Medicaid managed care and SCHIP managed care payment sampling and review



APPENDIX C

Treatment of Paid Date for Universe Selection

**Fee-for-Service Example
Selection of Sampling Units for FY2007, Quarter 2 (Jan - Mar)
Application of Payment Date and Payment Amount Criteria**

	Claim #1	Claim #2	Claim #3	Claim #4	Claim #5
December					Original payment December 15; \$45
January	Original payment January 12; \$45		Original payment January 6; \$280		
February	Adjusted February 27; new final paid amount \$60	Original payment February 28; \$1,200			Adjusted February 2; new final paid amount \$60
March	Adjusted March 25; new final paid amount \$70			Original payment March 31; \$500	
April		Adjusted April 20; new final paid amount \$960			
May			Adjusted May 12; new final payment \$375	Adjusted May 20; new final payment \$450	
Included in Q2 universe file provided 4/15:	Paid date = January 12; amount paid = \$45	Paid date = February 28; amount paid = \$1,200	Paid date = January 6; amount paid = \$280	Paid date = March 31; amount paid = \$500	Not included in Q2, original paid date prior to quarter
If claim selected for sample, state provides updates to Livanta:	February 27 adjustment information provided; March 25 adjustment not provided because adjustment occurred more than 60 days after January 12	Adjustment made on April 20 provided (since this is within 60 days of original payment date of February 28)	No update; adjustment occurred more than 60 days after original payment date	Adjustment made on May 20 provided (since this is within 60 days of original payment date of March 31)	N/A

APPENDIX C

Treatment of Paid Date for Universe Selection

**Managed Care Example
Selection of Sampling Units for FFY2007, Quarter 2 (Jan - Mar)
Application of Payment Date and Payment Amount Criteria**

	Claim #1	Claim #2	Claim #3	Claim #4	Claim #5
December	Capitation payment on 12/15 for managed care program enrollee for service period January 2007				
January		Capitation payment on 1/14 for enrollee in managed mental health plan for November 2006 service period	Individual stop-loss payment on 1/12 to managed mental health care plan for catastrophic costs incurred for beneficiary over prior six months		
February	Adjustment on 2/4 for capitation payment recovery due to death of enrollee on November 30				Capitation payment on 2/26 for managed care enrollee
March				Delivery kick-payment on 3/15 for delivery in December	
April					
Included in Q2 universe file provided 4/15:	Not included with Q2; it was included in Q1 submission due 1/15	State would include in Q2 universe	State would include in Q2 universe	State would include in Q2 universe	State would include in Q2 universe

APPENDIX C

Treatment of Paid Date for Universe Selection

	Claim #1	Claim #2	Claim #3	Claim #4	Claim #5
If claim selected for sample, state provides additional details:	If claim had been selected in the Q1 sample, the February adjustment would be provided with the additional Q1 detail on sampled claims	No adjustment made	No adjustment made	No adjustment made	No adjustment made

APPENDIX D

Fields for Universe Submission States send universe data to Lewin

When submitting the universe data to Lewin, states are required to provide all of the fields listed in the tables below. The first table contains the fee-for-service fields. The second lists the managed care fields. Note that in the FFS universe file, all fields are mandatory. This means every data element for every line item should be populated with a valid value.

Universe – Medicaid FFS and SCHIP FFS			
Field	Description	Mandatory for all sampling units	Notes
ICN	Unique claim identifier (e.g., ICN, TCN, other state issued number)	Mandatory	For “dummy” claims, be sure the ICN information can tie back to the payment.
Line Number	Line item number	Mandatory ; if not imbedded in ICN.	Indicate in documentation the line item number for headers (e.g., header line = 0)
Date Paid	<u>Original</u> date of payment	Mandatory	
Amount Paid	Amount of the original payment	Mandatory	Adjustments made within 60 days of original payment date will be requested after the sample is drawn; \$0 for denied claims
Provider Type	Provider type or MSIS category or other similar variable	Mandatory	<i>State data dictionary required</i>
Claim Type	Distinguish, for example, between inpatient, outpatient, professional, prescription, Medicare crossover, etc.	Mandatory	<i>State data dictionary required</i>
Payment Status	Indicator if the claim is paid or denied	Mandatory	

Medicaid managed care and SCHIP managed care			
Field	Description	Mandatory for all sampling units	Notes
ICN	Unique claim identifier (e.g., ICN, TCN, other state issued number)	Mandatory	Some states will need to use several variables to create a unique claim identifier.
Date Paid	Original date of payment	Mandatory	
Amount Paid	Amount paid	Mandatory	

APPENDIX D

**Fields for Universe Submission
States send universe data to Lewin**

Medicaid managed care and SCHIP managed care			
Field	Description	Mandatory for all sampling units	Notes
Program Indicator	Indicator of the program (TANF, PACE, LTC, Behavioral health)	Mandatory	<i>State data dictionary required</i>
Payment type	E.g., monthly capitation, delivery kick payment or other beneficiary-specific supplemental payment, individual reinsurance payment	Mandatory	<i>State data dictionary required</i>
Provider ID	Medicaid/SCHIP ID for the managed care organization	Mandatory	
Recipient ID	Recipient Medicaid/SCHIP number	Mandatory	
Recipient Name		Mandatory	
Recipient Rate Indicator	“Procedure code” or other rate cohort indicator	Mandatory	<i>State data dictionary required</i>
<i>Other recipient specific information such as:</i>	Recipient-specific information used to select rate cell		<i>State data dictionary required</i> The fields provided will depend upon the reimbursement methods used by the state’s managed care programs.
DOB			
Gender			
County			
Service Area Indicator			
Aid category			
Diagnosis			
Risk Score			
Coverage Period	Period of coverage this payment represents	Mandatory	May be prospective, concurrent, or retrospective
Claim Status	Paid or denied	Mandatory	

APPENDIX E

UNIVERSE DATA TRANSMISSION COVER SHEET

Complete and submit this cover sheet (electronically or in hard copy) with every PERM data submission.

State:

Date:

Contact person for data questions

Name:

Phone:

Email:

Title and Organization:

File Information

QUARTER <i>Check the appropriate boxes.</i>			
Q1	Q2	Q3	Q4

DATA CONTENTS <i>Check and complete the appropriate boxes.</i>				
	Medicaid FFS	SCHIP FFS	Medicaid Managed Care	SCHIP Managed Care
Initial Submission				
Replacement data, please describe (e.g., "all claims", "Medicare data")				

DATA DESCRIPTION <i>Check and complete the appropriate boxes. Please include a row describing your data documentation. Add more rows as necessary.</i>			
Data Description (e.g., Q1 Medicaid FFS; data documentation)	Data filename	File format (e.g., text, Excel, SAS)	Password (if included with data, send separately)

APPENDIX E

UNIVERSE DATA TRANSMISSION COVER SHEET

Control totals – Only for universe and replacement universe data. Add lines to these tables or attach tables as necessary.

Data filename:			
	Month	Month	Month
Total Lines - By Claim Type			
Total \$\$ - By Claim Type			

Data filename:			
	Month	Month	Month
Total Lines - By Claim Type			
Total \$\$ - By Claim Type			

Data filename:			
	Month	Month	Month
Total Lines - By Claim Type			
Total \$\$ - Claim Type			

Data filename:			
	Month	Month	Month
Total Lines - By Claim Type			
Total \$\$ - By Claim Type			

Data filename:			
	Month	Month	Month
Total Lines - By Claim Type			
Total \$\$ - By Claim Type			

APPENDIX E

UNIVERSE DATA TRANSMISSION COVER SHEET

Identification of potential data discrepancies

Please indicate whether there have been any major programmatic changes since the last quarter (e.g., introduction of a large managed care program, significant benefit changes or limitations introduced this quarter) that substantially impact the total dollars in the universe or distribution of dollars by claim type, compared to previous quarters. If possible, provide an estimate of the impact of the changes (e.g., 10% decrease in overall FFS spending in Q3).

**PRIOR TO SUBMITTING THIS DATA,
PLEASE CERTIFY BELOW THAT A QUALITY CONTROL CHECK WAS PERFORMED ON
EACH DATASET USING AT LEAST THE MINIMAL CHECKS IN THE DATA
SUBMISSION INSTRUCTIONS IN SECTION III.**

YES _____
Signature *Title*

NO _____
Signature *Title*

APPENDIX F

Fields for Sample FFS Claim and Line Details Submission

Livanta has included three tables to clarify the required fields for the Medicaid and SCHIP FFS claim detail submissions and for the Medicaid and SCHIP managed care sample claim and line detail data submission. The tables are:

- Sample Claim and Line Detail – Medicaid FFS and SCHIP FFS
- Sample Fixed Premium Payment – Medicaid FFS and SCHIP FFS (“Dummy Claims”)
- Medicaid managed care and SCHIP managed care (similar to Universe, except includes adjustments to sampled managed care claims)

1. Required Data Elements

States are required to provide all of the fields listed in the tables below. If you are unable to provide a value in the required field (the system does not contain such information), please document the reason in your data dictionary that is sent to Livanta. Decoded descriptions of all coded values are also required, either contained in the data dictionary or in excel tables.

2. FFS Header and Line Detail

States should submit the sample claim and line details in the format shown in the Sample Claim and Line Detail – Medicaid FFS and SCHIP FFS Table F-1 below. Livanta will provide an excel template with these standard fields upon initial contact with each state. The claim header information and line detail data are in a single file with the claim header repeated for each line item. If the state chooses not to utilize the Standard Format, then a consistent state format may be used. In all cases, **all claim header and line information for each sampling unit must be provided.**

Claim adjustments must also be included and must contain sufficient information to tie adjustments back to the original claim and line item being adjusted. Only adjustments occurring within the 60-day window should be included.

3. Medicare Part A and Part B Premiums and Other “Dummy Claims”

Medicare Part A and Part B premiums, HIPP payments, and PCCM payments are included in the universe and the state may have created “dummy claims” in order to sample individual premium payments. Livanta requires the fields noted in the Sample Fixed Premium Payment – Medicaid FFS and SCHIP FFS (“Dummy Claims”) Table F-2 below.

4. Managed Care Information

Medicaid Managed Care and SCHIP managed care samples will be provided to Livanta by Lewin via the state’s managed care universe files. However, Livanta will request any adjustments directly from the state. The expected format is contained in the Medicaid managed care and SCHIP managed care (same as Universe) Table F-3 below.

APPENDIX F

Fields for Sample FFS Claim and Line Details Submission

F-1: Sample Claim and Line Detail – Medicaid FFS and SCHIP FFS

Seq Num	Standard Field Name	Standard Field Description	Reqd By State	Output Group	"Dummy Claims" Field	Decode Values Reqd
1	Historical ICN	Claim control number of the claim that is contained in the Lewin Sample file, or relates to that claim. Adjustments are processed off of this ICN. Could be original or previous ICN. Can be added by Livanta.	N	Hdr		
2	ICN	Claim control number assigned by state for the current claim (is the original ICN if no adjustments, or the adjustment claim ICN). Is always populated.	Y	Hdr	Y	
3	Sample Year	YYYY of sample. Can be added by Livanta.	N	Hdr		
4	Sample Quarter	Sample quarter indicator formatted as the number of the quarter sampled. Can be added by Livanta.	N	Hdr		
5	PERM State	PERM Medicaid state supplying the claims information. Can be added by Livanta.	N	Hdr		
6	Claim Identifier	Identifier of the claim as contained in the Lewin sample file.	Y	Hdr		
7	Claim Type	Type of claim indicator, including whether the claim is an institutional, medical, or crossover claim; or Payment Type for "Dummy Claims" (Medicare Buy-in, HIPP, PCCM or other).	Y	Hdr	Y	Y
8	Adj Indicator	Y or N indicating whether this claim/line is an adjustment or original; only final action adjusted claims/lines will included in the standard claims data files that go to HDI.	N	Hdr		
9	Claim Category	Category of claim (e.g. institutional - hospital; institutional - LTC, dental, physician, pharmacy, hospital outpatient, etc.) All associated claim lines will reflect the sampling unit category. Can be determined by Livanta from other state-provided fields if necessary.	N	Hdr		Y
10	Payment Status	Indicates whether the claim has been paid = P or denied = D.	Y	Hdr		
11	Denial Code	Reason for denial of the claim.	Y	Hdr		Y

APPENDIX F

Fields for Sample FFS Claim and Line Details Submission

Seq Num	Standard Field Name	Standard Field Description	Reqd By State	Output Group	"Dummy Claims" Field	Decode Values Reqd
12	Amt Billed Clm	Submitted charge on the claim	Y	Hdr		
13	Amt Allowed Clm	Amount allowed on the claim	Y	Hdr		
14	Amt Copay Clm	Amount of copayment on the claim	Y	Hdr		
15	Amt TPL Clm	Amount of third party liability on the claim	Y	Hdr		
16	Amt Paid Clm	Amount paid on claim; or Payment Amt for "Dummy Claims"	Y	Hdr	Y	
17	Date Paid	Date paid.	Y	Hdr	Y	
18	DOS From Clm	From date of service on the claim; or Payment Period for "Dummy Claims"	Y	Hdr	Y	
19	DOS To Clm	To date of service on the claim; or Payment Period for "Dummy Claims"	Y	Hdr	Y	
20	Occurrence Code	Occurrence code - first occurrence if more than one provided. The code that identifies a significant event relating to an institutional claim that may affect payer processing.	N	Hdr		
21	Recipient ID	Recipient ID number	Y	Hdr	Y	
22	Recip Aid Category	Category of aid recipient is entitled to receive; or Eligibility for "Dummy Claims"	Y	Hdr	Y	Y
23	Recipient Name	Name of recipient in last name, first name MI sequence	Y	Hdr	Y	
24	Recipient DOB	Recipient date of birth	Y	Hdr	Y	
25	Recipient Gender	Recipient gender code (M or F)	Y	Hdr	Y	
26	Recipient City	Recipient city	N	Hdr		
27	Recipient State	Recipient state	N	Hdr		
28	Recipient Zip	Recipient zip code	N	Hdr		
29	Recipient County	Recipient county	N	Hdr		
30	TPL Group Num	Group number of third party liability coverage	N	Hdr		
31	TPL Member ID	Member ID of third party liability coverage	N	Hdr		
32	TPL Insured Name	Name of insured on TPL coverage	N	Hdr		
33	TPL Name-ID	Name or identification number of third party liability company	N	Hdr		
34	TPL Address 1	TPL Address 1	N	Hdr		
35	TPL Address 2	TPL Address 2	N	Hdr		
36	TPL City	TPL City	N	Hdr		
37	TPL State	TPL State	N	Hdr		
38	TPL Zip Code	TPL Zip Code	N	Hdr		

APPENDIX F

Fields for Sample FFS Claim and Line Details Submission

Seq Num	Standard Field Name	Standard Field Description	Reqd By State	Output Group	"Dummy Claims" Field	Decode Values Reqd
39	Medicare Crossover Indicator	Y or N indicator that the claim is a crossover claim from Medicare to Medicaid	Y	Hdr		
40	Billing Prov Number	Billing provider ID number	Y	Hdr		
41	Billing Prov Name	Billing provider name	Y	Hdr		
42	Billing Prov Type	Billing provider type	Y	Hdr		Y
43	Billing Prov Spec	Billing provider specialty code	Y	Hdr		Y
44	Billing Prov Addr 1	Billing provider address first line	Y	Hdr		
45	Billing Prov Addr 2	Billing provider address second line	Y	Hdr		
46	Billing Prov City	Billing provider city	Y	Hdr		
47	Billing Prov State	Billing provider state	Y	Hdr		
48	Billing Prov Zip	Billing provider zip code	Y	Hdr		
49	Billing Prov Phone	Billing provider phone number in xxxxxxxxxx format.	Y	Hdr		
50	Billing Prov Fax	Billing provider fax number in xxxxxxxxxx format.	Y	Hdr		
51	Billing Prov NPI	Billing provider's NPI, when available	N	Hdr		
52	Billing Prov Taxonomy	Billing provider's taxonomy, if available	N	Hdr		
53	ICD9 Proc Code 1	ICD9 surgical procedure code 1	Y	Hdr		
54	ICD9 Proc Code 2	ICD9 surgical procedure code 2	Y	Hdr		
55	ICD9 Proc Code 3	ICD9 surgical procedure code 3	Y	Hdr		
56	ICD9 Proc Code 4	ICD9 surgical procedure code 4	Y	Hdr		
57	ICD9 Proc Code 5	ICD9 surgical procedure code 5	Y	Hdr		
58	ICD9 Proc Code 6	ICD9 surgical procedure code 6	Y	Hdr		
59	Diag 1	Diagnosis code 1 (primary)	Y	Hdr		
60	Diag 2	Diagnosis code 2	Y	Hdr		
61	Diag 3	Diagnosis code 3	Y	Hdr		
62	Diag 4	Diagnosis code 4	Y	Hdr		
63	Diag 5	Diagnosis code 5	Y	Hdr		
64	Diag 6	Diagnosis code 6	Y	Hdr		
65	Diag 7	Diagnosis code 7	Y	Hdr		
66	Diag 8	Diagnosis code 8	Y	Hdr		
67	Diag 9	Diagnosis code 9	Y	Hdr		
68	DRG	Diagnosis Related Group (DRG) code, if applicable	Y	Hdr		
69	Number of Line Items	The total number of line items on the claim	Y	Hdr		
70	Line Item Number	Line number of the individual line item	Y	Line		
71	Sampled Ind	Indicates if the individual line was sampled. Added by Livanta if not provided by state.	N	Line		

APPENDIX F

Fields for Sample FFS Claim and Line Details Submission

Seq Num	Standard Field Name	Standard Field Description	Reqd By State	Output Group	"Dummy Claims" Field	Decode Values Reqd
72	Payment Status Line	Indicates whether the line has been paid = P or denied = D.	Y	Line		
73	Denial Code Line	Reason for denial of the line.	Y	Line		Y
74	Proc Code Line	Procedure code on the line (HCPCS code or CPT)	Y	Line		
75	Units	Submitted number of units (services) or drug dispensed	Y	Line		
76	Amt Billed Line	Submitted charge on the line	Y	Line		
77	Amt Allowed Line	Amount allowed on the line	Y	Line		
78	Amt Copay Line	Amount of copayment on the line	Y	Line		
79	Amt TPL Line	Amount of third party liability on the line	Y	Line		
80	Amt Paid Line	Amount paid on the line	Y	Line		
81	Proc Mod 1	Procedure Code Modifier - 1 on the line	Y	Line		
82	Proc Mod 2	Procedure Code Modifier - 2 on the line	Y	Line		
83	Proc Mod 3	Procedure Code Modifier - 3 on the line	Y	Line		
84	Proc Mod 4	Procedure Code Modifier - 4 on the line	Y	Line		
85	Rev Code	Revenue code	Y	Line		
86	Rev Code Description	Description of revenue code.	Y	Line		
87	Perf Prov Number	Performing (servicing) provider ID number	Y	Line		
88	Perf Prov Name	Performing (servicing) provider name	Y	Line		
89	Performing Prov Type	Performing provider type	Y	Line		Y
90	Performing Prov Spec	Performing provider specialty code	Y	Line		Y
91	Perf Prov Addr 1	Performing (servicing) provider address first line	Y	Line		
92	Perf Prov Addr 2	Performing (servicing) provider address second line	Y	Line		
93	Perf Prov City	Performing (servicing) provider city	Y	Line		
94	Perf Prov State	Performing (servicing) provider state	Y	Line		
95	Perf Prov Zip	Performing (servicing) provider zip code	Y	Line		
96	Perf Prov Phone	Performing (servicing) provider phone number in xxxxxxxxxx format.	Y	Line		
97	Perf Prov Fax	Performing (servicing) provider fax number in xxxxxxxxxx format.	Y	Line		
98	Perf Prov NPI	Performing provider's NPI, when	N	Line		

APPENDIX F

Fields for Sample FFS Claim and Line Details Submission

Seq Num	Standard Field Name	Standard Field Description	Reqd By State	Output Group	"Dummy Claims" Field	Decode Values Reqd
		available				
99	Perf Prov Taxonomy	Performing provider's taxonomy, if available	N	Line		
100	Drug Order Date	Date drug was prescribed for pharmacy claim.	Y	Line		
101	Non Covered Charges	Non-covered charges	Y	Line		
102	DOS From Line	From date of service on the line; or eligibility period for "Dummy Claims"	Y	Line	Y	
103	DOS To Line	To date of service on the line; or eligibility period for "Dummy Claims"	Y	Line	Y	
104	POS	Place of service	Y	Line		Y
105	TOS	Type of service; or Medicare Coverage Indicator for "Dummy Claims"	Y	Line	Y	Y
106	Diag Code Line	Specific diagnosis code associated with the line item	Y	Line		
107	Anesthesia Minutes	Anesthesia minutes used	N	Line		
108	EPSDT Code	Early & Periodic Screening, Diagnosis and Testing code	N	Line		
109	EMG Code	Electromyography code	N	Line		
110	COB Code	Coordination of Benefits indicator code	N	Line		
111	NDC Code	National Drug Code (NDC). Made up of labeler(mfr) + product + pkg size = 4/4/2 or 5/3/2 or 5/4/1 configurations. For Pharmacy only, amounts and DOS provided are copied to both claim and line level fields.	Y	Line		
112	RUG	Resource Utilization Group (RUG) code used for long term care payment. Only one for claim.	Y	Line		
113	APC	Ambulatory Payment Classification (APC) code used for outpatient payment. Only one for claim.	Y	Line		
114	Prior Authorization	Prior authorization number on the line. Will be the same on all lines if PA only available at the claim level.	Y	Line		
115	Adjustment Fields	States must provide all fields used for adjustments (adjustment pointer or other fields used to link the original and adjusted claims).	Y	0		

APPENDIX F

Fields for Sample FFS Claim and Line Details Submission

Seq Num	Standard Field Name	Standard Field Description	Reqd By State	Output Group	"Dummy Claims" Field	Decode Values Reqd
116	Adjustment Date	Date of the adjustment. Needed as adjustment information if different from Date Paid.	N	0		
117	Claim Category Fields	Fields necessary to categorize a claim (e.g. institutional - hospital; institutional - LTC, dental, physician, pharmacy, hospital outpatient, etc.)	Y	0		Y

APPENDIX F

Fields for Sample FFS Claim and Line Details Submission

Table F-2: Sample Fixed Premium Payment – Medicaid FFS and SCHIP FFS (“Dummy Claims”)

Seq Num	Standard Field Name	Standard Field Description	Reqd By State	"Dummy Claims" Field	Decode Values Reqd
1	ICN	Claim control number assigned by state for the current claim (if applicable)	Y	Y	
2	Claim Type	Type of claim indicator, including whether the claim is an institutional, medical, or crossover claim; or Payment Type for "Dummy Claims" (Medicare Buy-in, HIPPP, PCCM or other)	Y	Y	Y
3	Amt Paid Clm	Payment Amount for "Dummy Claims"	Y	Y	
4	Date Paid	Date paid	Y	Y	
5	Payment Period From Date	Payment Period for "Dummy Claims"	Y	Y	
6	Payment Period To Date	Payment Period for "Dummy Claims"	Y	Y	
7	Recipient ID	Recipient ID number	Y	Y	
8	Recip Aid Category	Eligibility type for "Dummy Claims"	Y	Y	Y
9	Recipient Name	Name of recipient in last name, first name MI sequence	Y	Y	
10	Recipient DOB	Recipient date of birth	Y	Y	
11	Recipient Gender	Recipient gender code (M or F)	Y	Y	
12	Medicare Cov Ind	Medicare coverage indicator (Part A, Part B, Part D)	Y	Y	Y
13	Elig From Date	Dates of eligibility for each Medicare Part	Y	Y	
14	Elig To Date	Dates of eligibility for each Medicare Part	Y	Y	

APPENDIX F

Fields for Sample FFS Claim and Line Details Submission

Table F-3: Medicaid managed care and SCHIP managed care (same as Universe)

Medicaid managed care and SCHIP managed care			
Field	Description	Mandatory for all sampling units	Notes
ICN	Unique claim identifier (e.g., ICN, TCN, other state issued number)	Mandatory	Some states will need to use several variables to create a unique claim identifier.
Date Paid	Original date of payment	Mandatory	
Amount Paid	Amount paid	Mandatory	
Program Indicator	Indicator of the program (TANF, PACE, LTC, Behavioral health)	Mandatory	<i>State data dictionary required</i>
Payment type	E.g., monthly capitation, delivery kick payment, or individual reinsurance payment	Mandatory	
Provider ID	Medicaid/SCHIP ID for the managed care organization	Mandatory	
Recipient ID	Recipient Medicaid/SCHIP number	Mandatory	
Recipient Name		Mandatory	
Recipient Rate Indicator	“Procedure code” or other rate cohort indicator	Mandatory	
<i>Other recipient specific information such as:</i>	Recipient-specific information used to select rate cell		
DOB			
Gender			
County			
Service Area Indicator			
Aid category			
Diagnosis			
Risk Score			
Coverage Period	Period of coverage this payment represents	Mandatory	May be prospective, concurrent, or retrospective
Claim Status	Paid or denied	Mandatory	
Adjustment Pointer	Pointer to the claim being adjusted (e.g., Historic ICN)		If this is an adjustment, submit with indicator linking to the original payment