



Payment Error Rate Measurement Program
CMS PERM Review Contractor,
Empower AI
8701 Park Central Drive Suite 400-B
Richmond, VA 23227

[[ProviderName]]
ATTN: [[ContactName]], [[ContactTitle]]
[[ContactAddress1]] [[ContactAddress2]]
[[ContactCity]], [[ContactState]] [[ContactZipcode]]

Date: [[RequestDate]]
Reference ID: [[PERMID]]
OMB Control Number: [[OMB#]]
NPI: [[NPI#]]

Request Type and Purpose: Additional Documentation Request (First Additional Documentation Request).
Subject: Additional Documentation – This is not a duplicate request.

To request a copy of this letter in Spanish, please contact the PERM Customer Service Department at 800-393-3068.

Para solicitar una copia de esta carta en Español, por favor de contactar al Departamento de Servicio al Cliente de PERM al 800-393-3068.

Dear Medicaid and/or CHIP Provider:

The Centers for Medicare & Medicaid Services (CMS), in partnership with the states, is measuring improper payments in Medicaid/CHIP under the Payment Error Rate Measurement (PERM)¹ program.

Reason for Selection: A claim submitted by or on behalf of you/your organization has been randomly selected for review under this program. The review will be completed by CMS' Review Contractor (RC), Empower AI.

Action: Send Additional Documentation: A request for the medical/supporting record was sent to you on xx/xx/xxxx for the beneficiary listed on the enclosed Claim Summary. Thank you for your response to the request. It has been determined by the reviewer, however, that additional documentation is needed to complete the review of this claim. The following pages provide details of the claim or service(s) selected for review, the requested supporting documentation, and submission instructions. **Your cooperation in submitting the additional documentation to us within fourteen (14) days is essential to ensure that the claim is accurately reviewed to determine proper payment.** Federal regulations require that you provide the documentation to support claims for Medicaid/CHIP services upon request². Providing medical records for Medicaid/CHIP patients does not violate the Health Insurance Portability and Accountability Act (HIPAA). **Patient authorization is NOT required to provide medical records in response to this request.** CMS and its contractors will remain in compliance with the Privacy Act and regulations.

When: [[MedrecDueDate]]

Please provide the requested documentation by [[MedrecDueDate]]. **A response is still required by [[MedrecDueDate]] even if you are unable to locate the requested information.**

Consequences: If you fail to deliver the requested additional documentation or contact us by [[MedrecDueDate]], the claim will be cited as an erroneous payment and your state agency may pursue recovery of payment for this claim from you.

Assistance: If you have questions, please contact our Customer Service Representatives at (800) 393-3068, Medical Records Manager Allison Keeley at PERMRC_ProviderInquiries@empower.ai, or your state PERM representative, _____, at _____ or _____. **Do NOT send records or patient information by email.**

Note: Selected providers could be contacted by the RC (via phone calls) throughout the PERM Audit: Initial Documentation Request, Additional Documentation Request (ADR), and No Response requests at the 30th, 45th, 60th, and 75th day, and final contact for cited errors.

¹ 42 CFR §431.804; Social Security Act Section 2107(b)(1) [42 CFR §431.950 et seq]; 45 CFR parts 160 and 164

² 42 CFR §431.950

SAMPLE

Payment Error Rate Measurement (PERM) Instructions for Submitting Requested Records/Documentation

To comply with this request, providers should review the attached Claim Summary page that identifies the specific patient, date of service, and the service(s) selected for review. Gather the documents shown on the attached Cover Sheet which are generally those needed to support the billed service(s). Please be sure that documentation (Notes, Plan of Care, etc.) issued from electronic records are signed and dated (electronic signature acceptable if permitted by state regulations). Once the documents are gathered, please choose **ONE** of the following methods to submit the records/documentation to the PERM Review Contractor.

If the patient records include another beneficiary's information (e.g., patient census), please ensure pages are redacted prior to sending.

1. Fax

- a) Place PERM Cover Sheet on top of each record submission and indicate how many pages are in each fax transmission.
- b) If your facility has *more than one* PERM ID request, please fax each submission separately.
- c) Please submit documentation for each PERM ID in as few fax transmissions as possible.
- d) Fax documents to: **1-804-515-4220**

2. Mail

- a) Place PERM Cover Sheet on top of each record submission.
- b) All documents must be complete and legible.
- c) Please do not staple or paper clip any pages together.
- d) If you choose to send the documentation on USB Flash Drive, CD, or DVD, the file(s) must be *encrypted*. Please submit the password for the encrypted USB Flash Drive, CD, or DVD via email to PERMRC_Encryption@empower.ai and include the PERM ID in the subject line. **Please do not submit medical records or patient information to this email address as it is not a secure method of transmission. Please note that USB flash drives cannot be returned to providers.**
- e) Mail requested documentation to:

**CMS PERM Review Contractor, Empower AI
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3. Electronic Submission of Medical Documentation (esMD)

Providers with an established relationship with a Health Information Handler (HIH) are encouraged to have their HIH submit the requested medical documentation via the gateway to **Electronic Submission of Medical Documentation (esMD)**. **If your facility does not have an established relationship with an HIH, esMD will not be an available submission method.** For more information, see <http://www.cms.gov/esMD/>. Please ensure that any documents submitted through esMD are routed to PERM Empower AI.

If you choose to submit medical records via CMS's esMD system, you must enter the Reference ID (PERM ID #) from the records request letter into the ESMD CASEID field. If you enter any other information in this field, the system will not be able to identify the record automatically which will result in additional processing time.

NOTE: We are not authorized to reimburse providers/suppliers for the cost of retrieving, copying, or mailing records. Therefore, we cannot accept invoices for service fees.

**Payment Error Rate Measurement (PERM)
REQUEST FOR ADDITIONAL DOCUMENTATION
COVER SHEET**

PERM-ID: [||PermID||]

Date: [||MRReSubDate||]

Patient Name: [BeneficiaryName]	Billing Provider Number: [ProviderID]
Date of Birth: [BeneficiaryDOB]	Billing Provider Name: [ProviderName]
Beneficiary ID: [BeneficiaryID]	
Date(s) of Service: [DOSFrom] - [DOSTo]	
Record Submission Due Date: [MedrecDueDate]	

Please help ensure accurate processing by placing this page on top of the records you are submitting.

The following **additional** documentation is needed:

In this space, the cover sheet specifies the exact documentation the Review Contractor needs to complete the review.

Note for state Medicaid and CHIP representatives:

State PERM representatives may view the language included in this section for a specific PERM ID in the State Medicaid Error Rate Findings (SMERF) system. The specific language included pulls from the "Document Type" field and "Reviewer Notes" field under the **Additional Requested Documents** section of the **Medical Records Requests** and **Additional Docs** tabs in SMERF.

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. If you are not the intended party, please notify the sender by telephone (800-393-3068) to arrange the return or destruction of the information and all copies.

SAMPLE

Payment Error Rate Measurement (PERM) Claim Summary

Please refer to the Request for Records Cover Sheet, Request for Additional Documentation Cover Sheet, Request for Resubmission of Documentation Cover Sheet, or Request for Resubmission of Additional Documentation Cover Sheet for a list of documents to submit in support of the billed service(s) below.

Billing Provider Number: [||ProviderID||]

Beneficiary/Patient Name: [||BeneficiaryName||]

Beneficiary ID: [||BeneficiaryID||]

Date of Birth: [||BeneficiaryDOB||]

Date(s) of Service: [||DOSFrom||] - [||DOSTo||]

Request Date: [||MRReSubDate||]

PERM-ID: [||PermID||]

Claim Category: [||ClaimCatNum||]

State Claim ID: [||StateClaimID||]

DUE DATE: [||MedrecDueDate||]

Diagnosis Code	Procedure Code	NDC Code	Rx Number	DRG	Amount Paid
[Diag1]	[Proc1]	[NdcCode1]	[RxNumber1]	[Drg]	[PaidAmt]
[Diag2]	[Proc2]	[NdcCode2]			
[Diag3]	[Proc3]	[NdcCode3]			
[Diag4]	[Proc4]	[NdcCode4]			
[Diag5]	[Proc5]	[NdcCode5]			
[Diag6]	[Proc6]	[NdcCode6]			
[Diag7]	[Proc7]	[NdcCode7]			
[Diag8]	[Proc8]	[NdcCode8]			
[Diag9]	[Proc9]	[NdcCode9]			