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: [||PERM ID||]
OMB Control Number: [||OMB#||]
NPI: [||NPI#||]

Request Type and Purpose: Initial Request for Records (First Request).
Subject: Records Request – This is an initial request for records.

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. Additional information about the PERM program is addressed on the CMS PERM website (www.cms.gov/PERM). Refer to the "Providers" link on the website.

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 a Copy of Original Documentation: Federal regulations require that you provide the medical record documentation to support claims for Medicaid/CHIP services upon request[2]. The following pages provide details of the claim or service(s) selected for review, the requested supporting documentation, and submission instructions. Please submit documentation as soon as possible, but no later than the due date provided below which is 75 days after the date of this initial request letter. A written response is required by the due date even if you are unable to locate the requested documents. Providing medical records for Medicaid/CHIP beneficiaries does not violate the Health Insurance Portability and Accountability Act (HIPAA). **Patient authorization is NOT required for the release of the requested documentation.** CMS and its contractors will remain in compliance with the Privacy Act and regulations. No reimbursement can be made for the cost of record reproduction or mailing.

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 documentation or contact us by [||**MedrecDueDate**||], 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

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:

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8701 Park Central Drive Suite 400-B
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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 RECORDS COVER SHEET

PERM-ID: [||PermID||]

Date: [||MRReSubDate||]

Beneficiary Name: [||BeneficiaryName||]	**Billing Provider Number:** [||ProviderID||]
Date of Birth: [||BeneficiaryDOB||]	**Billing Provider Name:** [||ProviderName||]
Beneficiary ID: [||BeneficiaryID||]	
Date(s) of Service: [||DOSFrom||] - [||DOSTo||]	
Category 1: Inpatient Hospital Services	
Record Submission Due Date: [||**MedrecDueDate**||]	

Please place this page on top of the documentation submission.
Please provide the name and contact phone number of the individual submitting the documents in support of this request. This information may be used if additional information is necessary.

Name: _____ Contact Phone Number: _____

Inpatient Hospital Services: Acute Inpatient, Long-Term Acute, Acute Inpatient Rehabilitation
Please submit all documents applicable to the date(s) of service noted to support the claim sampled. Some documents listed may not be necessary for all claims, **but please make every attempt to include the bolded items**. Please indicate which documents are being submitted. *If the list below is not applicable to your claim, please submit the documentation that supports the service(s) you billed as shown on the Claim Summary page.*

- ☐ **Admission Face Sheet/Coding Summary**
- ☐ **Admission History and Physical *(H and P) (signed and dated)***
- ☐ **Discharge Summary (*signed and dated*)**
- ☐ **Physician Orders *(signed and dated)***
- ☐ **Admit Order/Statement**
- ☐ **Physician Progress Notes *(signed and dated)***
- ☐ Consultation Reports/Notes *(signed and dated)*
- ☐ Medication Administration Record *(MAR)*
- ☐ Nursing Assessment/Notes
- ☐ Cardiovascular Testing Reports, i.e., Electrocardiogram, Echocardiogram, etc. (*signed and dated*)
- ☐ Laboratory Reports and Diagnostic Reports (i.e.: Radiology Reports, Pathology Reports, etc.)
- ☐ Operative and Procedure Reports/Notes *(signed and dated)*
- ☐ Anesthesia *(Pre- and Post-Op)* and Peri-operative Record/Notes *(with start and stop times, signed and dated)*
- ☐ Respiratory Therapy Notes *(signed and dated) broken down from Cardiovascular and Respiratory Reports*
- ☐ Physical Therapy: Evaluation/Re-evaluation/Notes *(signed and dated)*
- ☐ Speech Language Pathology: Evaluation/Re-evaluation/Notes *(signed and dated)*
- ☐ Occupational Therapy: Evaluation/Re-evaluation/Notes *(signed and dated)*

- ☐ Emergency Department Record and Admission Order/Notes *(signed and dated)*
- ☐ Ambulance Services/All Transfer Forms
- ☐ Labor and Delivery Record/Notes *(signed and dated)*
- ☐ Itemized Billing Sheet *(if required based on payment method)*
- ☐ Dialysis Treatment Record/Notes

Note: *Please submit the complete medical record with signatures as appropriate for the service(s) billed for the sampled claim. The documents listed above are frequently required for this category and service type. Please be sure to include these with your document submission, if applicable to the sampled claim.*

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||]			