

Payment Error Rate Measurement (PERM) Review Checklist Reporting Year 2023

To ensure that all documentation is submitted and reviewed please submit one checklist for each student's packet/documentation to be reviewed by the Office of Medicaid Services (OMS).

To: Office of Medicaid Services

District Name: _____

From (staff name): _____

Date Submitted (to OMS): _____

Date Due (to CMS): _____

Student Name: _____

Student Medicaid ID: _____

Date(s) of Service: _____

Services to be Reviewed: ☐ ST ☐ OT ☐ PT ☐ O&M ☐ Audiology ☐ Nursing

☐ DA/PTE ☐ Psychotherapy ☐ B-Mod ☐ PRS ☐ Family Support ☐ Crisis ☐ SPD

☐ SNT ☐ SDAC ☐ COVID-19 Testing

Check All Documents Being Submitted for Review:

☐ Copy of PERM Letter/Request

Consents: ☐ Medicaid Consent Form ☐ Non-IEP Nursing Consent, Telemedicine

☐ Student Consent Form for Voluntary COVID-19 Testing

☐ Parent/Caregiver/Guardian Agreement

☐ Referral Form(s)

☐ Physician's Medical Order or Prescription for Medication or Therapy

☐ Referral(s)

☐ Evaluation(s) or Assessment(s)

☐ Audiology Exam(s)

Treatment Plan(s): ☐ IEP/IFSP ☐ ITP/IHP ☐ IPOC

☐ Disease Reporting Form or Clinical Laboratory Improvement Amendments Waiver Log Entry

☐ Clinical Service Note(s)

☐ Behavior Modification Plan

☐ Progress Summary Note(s)

☐ Credential(s)

☐ Other Documents (specify): _____

Number of Pages Submitting: _____