PERM Review Contractor
FY 2016 Cycle 2 Claim Category Matrix

Category	Type of Service	Documents Requested (If applicable to sampled claim)	
1	**Inpatient Hospital Services:** • Acute Inpatient • Long Term Acute • Acute Inpatient Rehabilitation	• Admission Face Sheet / Coding Summary • Physician Coding Query Forms • Emergency Department Record & Admit / Notes • Admission History & Physical *(H&P)* • Physician Orders & Progress Notes (*signed and dated*) • Nursing Assessment / Notes • Consultation Reports / Notes • Cardiovascular& Respiratory Reports • Speech Language Pathology: Evaluation/Re-evaluation/Notes *(signed & dated with start /stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)* • Physical Therapy: Evaluation/Re-evaluation/Notes *(signed & dated with start & stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)*	• Occupational Therapy: Evaluation/Re-evaluation/Notes *(signed & dated with start & stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)* • Ambulance Services • Medication Administration Record *(MAR)* • Dialysis Record / Notes • Operative & Procedure Reports / Notes • Anesthesia *(Pre and Post-Op)* & Peri-operative Record / Notes *(with start and stop times)* • Laboratory & Diagnostic Tests / Reports • Labor and Delivery Record / Notes • Discharge Summary • All Transfer Forms • Itemized billing sheet (*if required based on payment method*)
2	**Psychiatric, Mental, & Behavioral Health:** • In/Outpatient Psychological, Psychiatric, and Behavioral Health Services • Drug and Alcohol In/Outpatient Svcs • Group Homes	• Admission Face Sheet / Coding Summary • Physician Coding Query Forms • Psychiatric Certification for Admission • Emergency Department Record / Notes • Clinic / Office Visit Record / Notes • Evaluation & Management *(E&M)* / Counseling Notes • Admission History and Physical *(H&P)* • Physician Orders (*signed and dated; include all orders relevant to sampled claim)* • Mental Health Progress / Therapy Notes / Daily Attendance Logs *(with start and stop times)*	• Psychiatric Evaluation / Testing • Treatment Plan & Goals *(ISP, IPP, IFSP, POC, in effect during sampled date/s of service)* • Consultation Reports / Notes • Nursing Assessment, Flowsheets/Notes • Medication Administration Record *(MAR)* • Treatment Administration Record / Notes • Discharge Summary • All Transfer Forms: *Voluntary, Involuntary, or Court Ordered* • Documentation of daily patient presence *(e.g. daily census, attendance log, etc.)*
3	**Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF):** • Nursing Home and Convalescent Centers • Chronic Care	• Admission Face Sheet • Physician Certification / Recertification *(signed and dated; in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame)* • Physician Orders *(signed and dated; include all orders relevant to sampled claim)* • Progress Notes for All Disciplines / Department *(to include physician's 60 day progress notes in effect during sampled date/s of service)*	• Medication Administration Record *(MAR)* • Treatment Administration Record / Notes • Documentation of daily patient presence (*e.g. daily census, attendance log, etc.)* • All Transfer Forms • Leave of Absence Documentation • Nursing Assessment, Notes, & Flowsheets • Treatment Plan *(in effect during sampled date/s of service)*

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4	**Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes**	• Admission Face Sheet • Physician Certification / Recertification (*signed and dated; in effect during sampled date/s of service- include cert/re-cert done prior to date/s of service if not completed during requested time frame*) • Physician Orders (*signed and dated; include all orders relevant to sampled claim*) • Progress Notes for All Disciplines / Departments *(to include physician's 60 day progress notes in effect during sampled date/s of service)*	• Medication Administration Record *(MAR)* • Treatment Administration Record / Notes • Documentation of daily patient presence *(e.g. daily census, attendance log, etc.)* • All Transfer Forms • Leave of Absence Documentation • Nursing Assessment, Notes, & Flowsheets • Annual physical exam *(if required)* • Treatment Plan *(in effect during sampled date/s of service)*
5	**Clinic Services:** • Hospital based clinics • Federally Qualified Health Centers (FQHC) • Indian Health Svcs • Outpatient Rural Health Clinic (RHC)	• Clinic Face Sheet • Encounter / Clinic Visit Record / Notes *(signed and dated)* • Evaluation and Management *(E&M)* / Counseling Notes • Treatment Plan *(in effect during sampled date/s of service)* • Dialysis Treatment Record / Notes	• Related Laboratory / Diagnostic Reports • Physician Orders (*signed and dated; include all orders relevant to sampled claim*) • Pharmacy Services and Medication Administration Record *(MAR)* • Dental and Diagnostic Service Records • Immunization Record • Nursing Notes
6	**Physicians & other Licensed Practitioners Services (*Includes APN, PA, Nurse Midwife & Midwife*)**	**Physician & Other Licensed Practitioners Services:** • Encounter/ Office Visit / Clinic Record & Notes *(signed and dated)* • Evaluation and Management *(E&M)* /Counseling Notes *(signed and dated)* • Related Laboratory / Diagnostic Reports • Treatment Plan *(in effect during sampled date/s of service)*	• Procedure Record / Notes • Immunization Record • Medication Administration Record *(MAR)* • Dialysis Treatment Records and Notes • Patient Education Documentation • Prior Authorization *(if required)* • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*

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7	**Dental & Oral Surgery Services**	**Dental & Oral Surgery Services:** • Dental or Orthodontic Assessment • Dental Chart *(related to sampled date/s of service)* • Dental or Orthodontic Clinical Notes (*signed and dated*) • Dental or Orthodontic Plan of Care *(in effect during sampled date/s of service)* ***Note**: Clinical Documentation (notes, plan of care, etc.) issued from electronic records must be signed and dated (electronic signature acceptable if permitted by state regulations).*	• Dental History • Dental X-Ray Notes (*please **do not** send x-rays*) • Procedure Record / Notes *(signed and dated)* • Prior Authorization *(if required)*
8	**Prescribed Drugs**	• Copy of Prescription in Original, Facsimile, Telephonic, or Electronic form: Front and Back (*if applicable*)—with patient name, date of birth, address, telephone number, physician name, & signature *(signature method as required/permitted by state regulations)* • Name of Drug, Dose, Route, Number Dispensed, & Number of Refills • NDC Number	• Prior Authorization (*if required*) • Member Pharmacy Signature Log / Proof of Delivery • Documented proof of acceptance or refusal of counseling • Signed Physician Medication Order for Skilled Nursing Facility *(SNF)* / Nursing Facility *(NF)* or Intermediate Care Facility *(ICF)* for Individuals with Intellectual Disabilities *(ICF/IID)* • Proof of Delivery to SNF, NF, ICF, ICF/IID or personal residence • Member Profile with Refill History for the <u>sampled medication</u>
9	**Home Health Services:** • Home Health Agency Services & Medical Supplies • Equipment and Appliances through the Agency	**Home Health Services:** • Physician Certification/Recertification *(Physician Certification signed and dated; in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame)* • Plan of Care *(in effect during sampled date/s of service)* • Physician Orders (*signed and dated; include all physician orders relevant to sampled claim*) • Initial / Intake Assessment • Nursing Assessments and Notes • Nursing Care Plan/Treatment Care Plan *(in effect during sampled date/s of service)* • Home Health Aide Notes / Worksheets *(time in & out)*	• Physical Therapy *(PT)* Assessments & progress toward goals *(time in & out)* • Speech Therapy *(ST)* Assessments & progress toward goals *(time in & out)* • Speech Language Pathology *(SLP)* Assessments & progress toward goals *(time in & out)* • Occupational Therapy *(OT)* Assessments & progress toward goals *(time in & out)* • DME Order/Prescription *(signed and dated)* • DME Signature Log/Proof of Delivery • Total Time Spent for Units Billed *(& unit identification i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)* • Infusion Therapy, medication/fluid name & administration specifics *(time in & out)* • Face to Face forms *(if required)*

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10	**Personal Support Services:** • Personal Care Svcs Personal Care • Personal Care Attendant, Aide, Homemaker Services, & Respite Care • Targeted Case Management Svcs • Private Duty Nursing • Meal Delivery Svcs	**Personal Care Services *(Qualified Service Provider, Personal Care Attendant, Aide, Homemaker services & Respite Care)*:** • Physician Certification / Recertification *(Physician Certification signed and dated; in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame)* • Statement of Medical Necessity • Physician Orders (*signed and dated; include all orders relevant to sampled claim*)	• Initial Intake Assessment / Reassessment *(as relevant to dates of service)* • Timesheet, completed & signed *(include description of services approved & provided)* • Recipient's signature / proof of service receipt • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)* • Service / Treatment Plan & Goals *(in effect during sampled date/s of service)*
		Case Management/Targeted Case Management Services: • Referral for Case Management / Statement of Necessity • Case Management Care Plan / Updates & Notes *(in effect during sampled date/s of service; including telephonic contact*) • Goals / Timelines / Outcome Measures *(with description of services approved & provided)*	• Case Management Invoice / Billing / Timesheet • Recipient's signature / proof of service receipt • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*
		Private Duty Nursing: • Physician Orders / Statement of Medical Necessity (*signed and dated; include all physician orders relevant to sampled claim*) • Initial / Intake Assessment / Reassessment	• Nursing Flowsheets/Notes *(completed & signed with time in & out)* • Recipient's signature / proof of service receipt • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*
		Meal Delivery Services: • Referral for Services • Meal Delivery Records / Signature Logs / Proof of Delivery	
11	**Hospice Services:** • Services provided at Home, Nursing Facility, Hospital, or Hospice Facility	**Hospice Services:** • Admission Face Sheet • Physician Certification / Recertification *(Physician Certification signed and dated; in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame)* • Physician's Orders *(signed and dated; include all orders relevant to sampled claim)* • Hospice Benefit Election / Revocation Forms	• Initial / Intake Assessment • Hospice Nurse Visit and Progress Notes • Multidisciplinary Care Plan and Notes *(in effect during sampled date/s of service)* • Social Work Notes • Home Health Aide Notes / Worksheets • Medication Administration Record *(MAR)* • Documentation of daily patient presence *(e.g. daily census, attendance log, etc.)*

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12	**Physical, Occupational, Respiratory Therapies, Speech Language Pathology, Audiology, & Rehabilitation Services, Ophthalmology, Optometry, & Optical Services Necessary Supplies & Equipment**	**Physical, Occupational, Respiratory, Speech Language Pathology, Audiology, & Rehabilitation Services, Ophthalmology, Optometry, & Optical Services, Necessary Supplies & Equipment** • Orders (*signed and dated; include all physician or authorized relevant practitioner's orders related to sampled claim*) • Treatment Plan & *Goals (in effect during sampled date/s of service)* • Physical Therapy: Evaluation / Re-evaluation / Notes *(signed & dated with start & stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)* • Occupational Therapy: Evaluation/ Re-evaluation/Notes *(signed & dated with start & stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)* • Speech Language Pathology: Evaluation/Re-evaluation/Notes *(signed & dated with start /stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)*	• Audiology: Evaluation / Re-evaluation / Notes *(signed & dated with start & stop times, & total time spent for units billed i.e., 15 min, 30 min, 1hr, 1 visit, etc.)* • Respiratory Therapy: Evaluation and Re-evaluation / Notes *(signed & dated with start & stop times, & total time spent for units billed i.e., 15 min, 30 min, 1hr, 1 visit, etc.)* • Prior Authorization for Durable Medical Equipment needed for provision of therapy services (*if required*) • Durable Medical Equipment Receipt Signature Log / Proof of Delivery • Diagnostic Test Results • Ophthalmology Visit and Progress Notes *(signed and dated)* • Optometry and Optical Visit Notes *(signed and dated)* • Eyeglass / Optician Invoices • Proof of Delivery / Signature Logs
13	**Day Habilitation, Adult Day Care, Foster Care, or Waiver Programs & School Based Services**	**Home and Community Based Services (HCBS), Adult Day Care, Foster Care, or Waiver Services:** • Orders from identified qualified provider *(if required)* • Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records *(signed and dated, with amount, type, start/stop times, and duration)* • Service/Treatment Plan & Goals (*in effect during sampled date/s of service)* • Individual Education Plan (IEP); Individual Program Plan (IPP); Individual Service Plan (ISP); Individual Family Service Plan (IFSP) *(in effect during sampled date/s of service)*	• Case Management / Supervisory Visit Notes • DME Signature Log / Proof of Delivery Transportation Provider: • Account Ledger and Billing Statements • Ground Mileage / Pick-up & Drop Off Details

		School Based Services: • Orders from identified qualified provider • Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, & Records *(signed and dated, with amount, type, start/stop times, and duration)* • Psychological Testing, Mental Health counseling notes, treatment plan, & progress toward goals • Case Management, Skilled Nursing, Social Work, &/or Personal Care Service • Service/Treatment Plan & Goals (*in effect during sampled date/s of service)* • Individual Education Plan *(IEP)*; Individual Program Plan *(IPP)*; Individual Service Plan *(ISP)*; Individual Family Service Plan *(IFSP) (in effect during sampled date/s of service)*	• Assistive Mobility, Vision, &/or Hearing Technology Device • Deaf Interpreter or Sign Language Service • PT, OT, SLP, Audiology, Vision, and Respiratory Therapy *(RT)*: Evaluation and Re-evaluation/Notes • Medication Administration Record *(MAR)* Transportation Provider: • Account Ledger and Billing Statements Ground Mileage / Pick-up & Drop Off Details
Category	**Type of Service**	**Documents Requested (If applicable to sampled claim)**	
14	**Laboratory, X-ray & Imaging Services**	**Laboratory, X-ray, & Imaging Services:** • Physician Order Sheet *(signed and dated)* • Laboratory Report / Results	• Radiology / Imaging Report / Results & Interpretation (*please **do not** send x-rays)*
15	**Outpatient Hospital Services:** • Outpatient • Emergency Svcs	**Outpatient Hospital Services:** • Admission Face Sheet / Coding Summary • Physician Coding Query Forms • Emergency Department Record / Notes • Admission History & Physical *(H&P)* • Physician Orders & Progress Notes (*signed and dated*) • Nursing Assessment / Notes • Consultation Reports / Notes • Cardiovascular & Respiratory Reports • Physical & Occupational Therapy Assessments / Notes • Speech Language Pathology *(SLP)* Assessments / Notes • Ambulance Services	• Medication Administration Record *(MAR)* • Dialysis Record / Notes • Operative & Procedure Reports / Notes • Anesthesia (Pre and Post-Op) & Peri-operative Record / Notes *(with start and stop times)* • Laboratory & Diagnostic Tests / Reports • Labor and Delivery Record / Notes • Discharge Summary • All Transfer Forms • Itemized billing sheet (*if required based on payment method*)
16	**Durable Medical Equipment (DME) & Supplies, Prosthetic / Orthopedic Devices, & Environmental Modifications**	**Durable Medical Equipment, Supplies, Prosthetic Orthopedic Devices, & Environmental Modifications:** • Physician Orders (*signed and dated; include all relevant orders for the sampled claim*) • Durable Medical Equipment / Supplies Prescription (*signed and dated*) • Prosthetic / Orthopedic Device Assessments / Notes (*dated*)	• Proof of Delivery / Signature Logs *(dated)* • Prior Authorization for Devices, Prosthetics, Equipment, Environmental Modifications, &/or Supplies *(if required)* • Invoice for Services *(dated)* • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*

Category	Type of Service	Documents Requested (If applicable to sampled claim)
17	**Transportation & Accommodations**	**Transportation & Accommodations:** • Emergency Medical Transportation Records with documented medical necessity of Ambulance transport *(if applicable)* • Transportation Schedule for requested dates of service • Starting Point and Destination / Odometer Readings • Transportation Log with Member Signature • Ground Mileage / Air Mileage Details • Physician Order for Transportation / Accommodations (*if applicable)* • Documentation reflecting Medical Necessity for Transportation and Accommodations • Chaperone Documentation, if appropriate *(approval/authorization)*
18	**Denied Claims**	No Documents / Medical Records Requested
19	**Crossover Claims**	No Documents / Medical Records Requested
30	**Capitated Care/Fixed Payments** • Fixed Payments for Primary Care • Case Management (PCCM) • Medicare Part A Premiums • Medicare Part B Premiums • Health Insurance Premium Payments (HIPP) • Aggregate Payments	No Documents / Medical Records Requested
50	**Managed Care** • Capitated Payments to HMO, HIO, or PACE Plan • Capitated Payments to Prepaid Health Plans (PHPs)	No Documents / Medical Records Requested
99	**UNKNOWN**	Claim Data is Individually Reviewed for Category Determination