PERM Review Contractor
RY 2025 Cycle 1 Claim Category Matrix

**Instructions for record submissions for all categories:**

***Note:*** *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 the claim, please submit the documentation that supports the service(s) billed as shown on the Claim Summary page.*

***Note:*** *Please submit the complete medical record with signatures as appropriate for the service(s) billed for the sampled claim. The documents listed 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.*

| Category | Type of Service | Documents Requested (if applicable to sampled claim) |
|---|---|---|
| 1 | **Inpatient Hospital Services:**<br>• Acute Inpatient<br>• Long-Term Acute<br>• Acute Inpatient Rehabilitation | • **Admission Face Sheet/Coding Summary**<br>• **Admission History and Physical *(H and P) (signed and dated)***<br>• **Discharge Summary (*signed and dated*)**<br>• **Physician Orders *(signed and dated)***<br>• **Admit Order/Statement**<br>• **Physician Progress Notes *(signed and dated)***<br>• Consultation Reports/Notes *(signed and dated)*<br>• Medication Administration Record *(MAR)*<br>• Nursing Assessment/Notes<br>• Cardiovascular Testing Reports, i.e., Electrocardiogram, Echocardiogram, etc. (*signed and dated*)<br>• Laboratory Reports and Diagnostic Reports (i.e.: Radiology Reports, Pathology Reports, etc.)<br>• Operative and Procedure Reports/Notes *(signed and dated)*<br>• Anesthesia *(Pre- and Post-Op)* and Peri-operative Record/Notes *(with start and stop times, signed and dated)*<br>• Respiratory Therapy Notes *(signed and dated) broken down from Cardiovascular and Respiratory Reports*<br>• Physical Therapy: Evaluation/Re-evaluation/Notes *(signed and dated)*<br>• Speech Language Pathology: Evaluation/Re-evaluation/Notes *(signed and dated)*<br>• Occupational Therapy: Evaluation/Re-evaluation/Notes *(signed and dated)*<br>• Emergency Department Record and Admission Order/Notes *(signed and dated)*<br>• Ambulance Services /All Transfer Forms<br>• Labor and Delivery Record/Notes *(signed and dated)*<br>• Itemized Billing Sheet *(if required based on payment method)*<br>• Dialysis Treatment Record/Notes |
| 2 | **Psychiatric, Mental Health, and Behavioral Health Services:**<br>• In/Outpatient Psychological, Psychiatric, and Behavioral Health Services<br>• Drug and Alcohol In/Outpatient Services<br>• Group Homes | • **Clinic/Office Visit Record/Notes *(signed and dated)***<br>• **Documentation of Daily Patient Presence, if inpatient *(e.g., daily census, etc.)***<br>• **Treatment Plan and Goals *(Individual Service Plan, Individual Program Plan, Individual Family Service Plan, Plan of Care in effect during sampled date/s of service)***<br>• **Psychiatric Certification for Admission**<br>• **Admission History and Physical *(H and P)***<br>• **Psychiatric Evaluation/Testing**<br>• **Admission Face Sheet/Coding Summary**<br>• **Discharge Summary**<br>• **Physician Orders (*signed and dated; include all orders relevant to sampled claim)***<br>• **Physician Progress Notes (*signed and dated*) relevant to sampled claim**<br>• **Mental Health Progress/Therapy Notes *(with start and stop times, signed and dated)***<br>• **Medication Administration Record *(MAR)***<br>• Nursing Assessment, Flowsheets/Notes<br>• Treatment Administration Record/Notes<br>• Ambulance Services *(if applicable)*<br>• All Transfer Forms: *Voluntary, Involuntary, or Court Ordered* |

| Category | Type of Service | Documents Requested (if applicable to sampled claim) |
|---|---|---|
| | | • Emergency Department Record/Notes *(signed and dated)*<br>• Evaluation and Management *(E and M)*/Counseling Notes *(with start and stop times if timed service, signed and dated)* |
| 3 | **Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF):**<br>• Nursing Home and Convalescent Centers<br>• Chronic Care | • **** PLEASE DO NOT SEND MINIMUM DATA SET (MDS) DOCUMENTS****<br>• **Admission Face Sheet**<br>• **Physician Orders *(signed and dated; include all orders relevant to sampled claim)***<br>• **Physician/Non-Physician Provider Progress Notes, including the regulatory 30-day or 60-day physician visit(s) notes <u>which must be dated within 30 days or 60 days, as applicable, prior to the sampled date of service or date of service range</u> *(signed and dated)***<br>• **Documentation of Daily Patient Presence (*e.g., daily census, attendance log, etc.)***<br>• **Nursing Assessment, Notes, and Flowsheets *(signed and dated)***<br>• Medication Administration Record *(MAR)*<br>• Treatment Administration Record/Notes (*TAR*)<br>• Physician Treatment Plan/Physician Plan of Care *(in effect during sampled date/s of service)*<br>• 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)*<br>• All Transfer Forms (*e.g., to hospital, other facilities*)<br>• Leave-of-Absence Documentation (*sign out forms*) |
| 4 | **Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes** | • **Annual Physical Exam**<br>• **Documentation of Daily Patient Presence *(e.g., daily census, attendance log, etc.)***<br>• **Physician Orders (*signed and dated; include all orders relevant to sampled claim*)**<br>• **Daily Progress Notes *(signed and dated, in effect during sampled date(s) of service)***<br>• **Treatment Plan/Plan of Care *(signed and dated, in effect during sampled date/s of service)***<br>• **Signature Page for the Plan of Care applicable to sampled date(s) of service (Care Plan Meeting attendance list and documentation of verbal consent in lieu of in person meeting/signed consent)**<br>• Leave-of-Absence Documentation (*sign out forms*)<br>• Medication Administration Record *(MAR)*<br>• Treatment Administration Record/Notes<br>• All Transfer Forms<br>• Nursing Assessment, Notes, and Flowsheets *(signed and dated)*<br>• 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*)<br>• Admission Face Sheet |
| 5 | **Clinic Services:**<br>• Hospital-based Clinics<br>• Federally Qualified Health Centers (FQHC)<br>• Indian Health Services (IHS)<br>• Rural Health Clinic (RHC) | • **Encounter/Clinic Visit Record/Notes *(signed and dated)***<br>• ***Please note: If a global obstetrician service is billed, please submit the antepartum/prenatal, delivery, and postpartum/postnatal records. Please submit records for all antepartum/prenatal visits if more than one visit was billed***<br>• **Treatment Plan *(in effect during sampled date/s of service)***<br>• **Signature Page for Plan of Care applicable to sampled date/s of service (Care Plan Meeting attendance list and documentation of verbal consent in lieu of in person meeting/signed consent)**<br>• **Pharmacy Services and Medication Administration Record *(MAR)***<br>• **For claims pertaining solely to Prescribed Drugs, please submit:**<br>  ○ **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, and Signature *(signature method as required/permitted by state regulations)***<br>  ○ **National Drug Code *(NDC)* Number**<br>  ○ **Member Profile with Refill History for the <u>Sampled Medication</u>** |

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|---|---|---|
| | | ○ **Documented Proof of Beneficiary Acceptance or Refusal of Counseling**<br>○ **Member Pharmacy Signature Log/Proof of Delivery**<br>○ **Proof of Reversal *(if applicable)***<br>• **Dental and Diagnostic Service Records *(signed and dated)***<br>• Clinic Face Sheet<br>• Evaluation and Management *(E and M)*/Counseling Notes *(signed and dated)*<br>• Physician Orders (*signed and dated; include all orders relevant to sampled claim*)<br>• Nursing Notes *(signed and dated)*<br>• Related Laboratory/Diagnostic Reports<br>• Immunization Record<br>• Dialysis Treatment Record/Notes |
| 6 | **Physicians and Other Licensed Practitioners Services (Includes Advanced Practice Nurse, Physician Assistant, Nurse Midwife, and Midwife)** | • **Encounter/Office Visit/Clinic Record/Notes *(signed and dated)***<br>• **Patient Education Documentation**<br>• **Prenatal/Antepartum/Peripartum/Postpartum Record/Notes *(signed and dated)***<br>• ***Please submit records for <u>all</u> antepartum visits if more than one visit was billed***<br>• **Evaluation and Management *(E and M)*/Counseling Notes *(signed and dated)***<br>• **Related Laboratory/Diagnostic Reports**<br>• **Treatment Plan *(in effect during sampled date/s of service)***<br>• **Procedure Record/Notes *(signed and dated)***<br>• **Immunization Record**<br>• **Medication Administration Record *(MAR)***<br>• **Total Time Spent for Units Billed *(i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• Dialysis Treatment Record/Notes (*if applicable)*<br>• Referral Documentation *(if applicable)* |
| 7 | **Dental and Oral Surgery Services** | • **Dental or Orthodontic Clinical Notes including patient identifiers (*signed and dated*)**<br>• **Dental X-Ray Notes/DDS interpretation of X-Rays, if X-Rays are billed (*please do not send X-Ray films*)**<br>• Dental or Orthodontic Assessment *(signed and dated)*<br>• Dental Chart *(related to sampled date/s of service)*<br>• Dental or Orthodontic Plan of Care *(in effect during sampled date/s of service)*<br>• Dental History<br>• Procedure Record/Notes *(signed and dated)*<br>• Anesthesia *(Pre- and Post-Op)* and Peri-operative Record/Notes, if applicable *(signed and dated; with start and stop times)*<br>• Operative Record/Notes, if applicable *(signed and dated)* |
| 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, and Signature *(signature method as required/permitted by state regulations)***<br>• **National Drug Code *(NDC)* Number**<br>• **Member Profile with Refill History for the <u>Billed Medication</u>**<br>• **Documented Proof of Beneficiary Acceptance or Refusal of Counseling**<br>• Member Pharmacy Signature Log/Proof of Delivery<br>• Physician Medication Order for Skilled Nursing Facility *(SNF)*, Nursing Facility *(NF)*, Intermediate Care Facility *(ICF),* or ICF for Individuals with Intellectual Disabilities *(ICF/IID) (signed and dated)*<br>• Proof of Delivery to SNF, NF, ICF, ICF/IID, or Personal Residence<br>• Name of Drug, Dose, Route, Number Dispensed, and Number of Refills<br>• Medication Administration Record (*MAR*), *if medication given in clinic/physician office*<br>• Physician Progress Note, *if medication given in clinic/physician office*<br>• Proof of Timely Claim Reversal (*if applicable*) |

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|---|---|---|
| 9 | **Home Health Services:**<br>• Home Health Agency Services and Medical Supplies<br>• Equipment and Appliances through the Agency | • **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) (Also known as 485)***<br>• **Plan of Care *(in effect during sampled date/s of service)***<br>• **Signed and dated Plan of Care Signature Page applicable to sampled date/s of service**<br>• **Physician Orders (*signed and dated; include all physician orders relevant to sampled claim*)**<br>• **Therapy (Physical Therapy/Occupational Therapy/Speech Language Pathology) Assessments, Treatment Plans, Progress Toward Goals, and Treatment Record/Notes *(time in and out)***<br>• Documentation of Physician Face-to-Face Contact/Encounter with the Beneficiary (*if required*)<br>• Initial/Intake Assessment<br>• Nursing Assessments and Notes *(time in and out; signed and dated)*<br>• Nursing Care Plan/Treatment Care Plan *(in effect during sampled date/s of service)*<br>• Home Health Aide Plan of Care<br>• Home Health Aide Notes/Worksheets *(time in and out; signed and dated by aide and beneficiary or authorized individual)*<br>• Order/Prescription for Medical Supplies, Equipment, and Appliances *(signed and dated)*<br>• Signature Log/Proof of Delivery for Medical Supplies, Equipment, and Appliances<br>• Total Time Spent for Units Billed *(and unit identification, i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)*<br>• Infusion Therapy, Medication/Fluid Name and Administration Specifics *(time in and out, signed and dated by infusion nurse)* |
| 10 | **Personal Support Services:**<br>• Personal Care Services<br>  ○ Qualified Service Provider, Personal Care Attendant, Aide, Homemaker Services, and Respite Care<br>• Case Management/ Targeted Case Management Services<br>• Private Duty Nursing<br>• Meal Delivery Services | **<u>Personal Care Services (*Qualified Service Provider, Personal Care Attendant, Aide, Homemaker Services, and Respite Care*):</u>**<br>• **Timesheet, Completed and Signed *(include description of services approved and provided)***<br>• **Electronic Visit Verification *(EVV)* record, Worksheets and Records *(signed and dated; with type of documentation [e.g., progress notes, flowsheets, EVV, etc.], start/stop times, and duration)***<br>• **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)***<br>• **Service/Treatment Plan and Goals *(in effect during sampled date/s of service)***<br>• **Signature Page for Plan of Care applicable to sampled date/s of service**<br>• **Physician Orders (*signed and dated; include all orders relevant to sampled claim*)**<br>• **Initial Intake Assessment/Reassessment *(as relevant to dates of service)***<br>• **Beneficiary's Signature/Proof-of-Service Receipt**<br>• **Total Time Spent for Units Billed *(i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• Statement of Medical Necessity<br><br>**<u>Case Management/Targeted Case Management Services:</u>**<br>• **Case Management Care Plan/Updates and Notes *(in effect during sampled date/s of service; including telephonic contact*)**<br>• **Case Management Invoice/Billing/Timesheet**<br>• **Beneficiary's Signature/Proof-of-Service Receipt**<br>• **Total Time Spent for Units Billed *(i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• Referral for Case Management/Statement of Necessity<br><br>**<u>Private Duty Nursing:</u>**<br>• **Physician Orders/Statement of Medical Necessity (*signed and dated; include all physician orders relevant to sampled claim*)**<br>• **Total Time Spent for Units Billed *(i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• **Initial/Intake Assessment/Reassessment** |

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|---|---|---|
| | | • **Nursing Flowsheets/Notes *(completed and signed and dated; with time in and out)***<br>• **Beneficiary's Signature/Proof-of-Service Receipt**<br><br>**<u>Meal Delivery Services:</u>**<br>• **Meal Delivery Records/Signature Logs/Proof of Delivery**<br>• Referral for Services |
| 11 | **Hospice Services:**<br>• Services Provided at Home, or in a Nursing Facility, Hospital, or Hospice Facility | • **Admission Face Sheet**<br>• **Initial/Intake Assessment (completed by Registered Nurse) *(signed and dated)***<br>• **Hospice Nurse Visit and Progress Notes *(signed and dated)***<br>• **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)***<br>• **Physician's Orders *(signed and dated; include all orders relevant to sampled claim)***<br>• **Hospice Benefit Election/Revocation Forms *(signed and dated)***<br>• **Medication Administration Record *(MAR)***<br>• **Documentation of Daily Patient Presence *(e.g., daily census provided by hospice company); Note: Even when acting as a passthrough for room and board charges, documentation is required***<br>• Multidisciplinary Care Plan and Notes (*may be called Interdisciplinary Group or Interdisciplinary Team*) *(in effect during sampled date/s of service)*<br>• Social Work Notes<br>• Home Health Aide Notes/Worksheets |
| 12 | **Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology, and Rehabilitation Services; Ophthalmology, Optometry, and Optical Services; Necessary Supplies and Equipment** | • **Orders (*signed and dated; include all physician or authorized relevant practitioner's orders related to sampled claim*)**<br>• **Treatment Plan, Goals, and Signature Page *(in effect during sampled date/s of service)***<br>• **<u>Physical Therapy</u>: Evaluation/Re-evaluation/Notes, including Progress Toward Goals *(signed and dated, with start and stop times, and total time spent for units billed, i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• **<u>Occupational Therapy</u>: Evaluation/Re-evaluation/Notes, including Progress Toward Goals *(signed and dated, with start and stop times, and total time spent for units billed, i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• **<u>Speech Language Pathology</u>: Evaluation/Re-evaluation/Notes, including Progress Toward Goals *(signed and dated with start/stop times, and total time spent for units billed, i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• **<u>Audiology</u>: Evaluation/Re-evaluation/Notes, including Progress Toward Goals *(signed and dated, with start and stop times, and total time spent for units billed, i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• **<u>Respiratory Therapy</u>: Evaluation and Re-evaluation/Notes, including Progress Toward Goals *(signed and dated, with start and stop times, and total time spent for units billed, i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• **<u>Ophthalmology:</u> Visit and Progress Notes *(signed and dated)***<br>• **<u>Optometry and Optical:</u> Visit Notes *(signed and dated),* Eyeglass/Optician Invoices**<br>• Diagnostic Test Results/Documentation of Necessity<br>• Durable Medical Equipment, Prosthetic, Orthotic, and Supply Orders<br>• Proof of Delivery/Signature Logs |
| 13 | **Day Habilitation, Adult Day Care, Foster Care, or Waiver Programs and School-Based Services** | **<u>Home and Community-Based Services (*HCBS*), Adult Day Care, Foster Care, or Waiver Services:</u>**<br>• **Daily Progress Notes, Flowsheets, Timesheets, Electronic Visit Verification *(EVV)* record, Worksheets, and Records *(signed and dated; with type of documentation [e.g., progress notes, flowsheets, EVV, etc.], start/stop times, and duration)***<br>• **Attendance Logs**<br>• **Service/Treatment Plan and Goals (*in effect during sampled date/s of service)*** |

| Category | Type of Service | Documents Requested (if applicable to sampled claim) |
|---|---|---|
| | | • **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)***<br>• **Signature page or video conference attendee list for IEP, ISP, or IFSP for plan <u>in effect for date/s of service</u>**<br>• **Case Management/Supervisory Visit Notes**<br>• Nursing Assessment and Nursing Notes *(signed and dated including type, start/stop times, and duration) (if applicable)*<br>• Durable Medical Equipment Signature Log/Proof of Delivery<br>• Orders from Identified Qualified Provider *(if required)*<br><br>**<u>School-Based Services (documentation required in addition to above):</u>**<br>• **Note: Records for services provided in a school setting are considered 'medical records' when billed to a state's Medicaid program or Children's Health Insurance Program (CHIP).**<br>• **Individual Education Plan *(IEP)*; Individual Program Plan *(IPP)*; Individual Service Plan *(ISP)*; Individual Family Service Plan *(IFSP)* *(<u>in effect during sampled date/s of service</u>, include Physician Orders if required)***<br>• **Signature page or video conference attendee list for IEP, ISP, or IFSP for plan in effect for date of service**<br>• **Daily Progress Notes, Flowsheets, Worksheets, and Records *(signed and dated including type, start/stop times, and duration)***<br>• **Beneficiary Attendance Logs**<br>• **Physical Therapy *(PT)*, Occupational Therapy *(OT)*, Speech Language Pathology *(SLP)*, Audiology, Vision, and Respiratory Therapy *(RT)*: Evaluation and Re-evaluation/Notes *(signed and dated including type, start/stop times, and duration)***<br>• Orders from Identified Qualified Provider *(signed and dated)*<br>• Psychological Testing, Mental Health Counseling Notes, Treatment Plan, and Progress Toward Goals<br>• Case Management, Skilled Nursing, Social Work, and/or Personal Care Service Notes *(signed and dated including type, start/stop times, and duration)*<br>• Assistive Mobility, Vision, and/or Hearing Technology Device<br>• Deaf Interpreter or Sign Language Service<br>• Medication Administration Record *(MAR)*<br>• Service/Treatment Plan and Goals (*in effect during sampled date/s of service)*<br><br>**<u>Transportation Provider:</u>**<br>• **Account Ledger and Billing Statements**<br>• **Ground Mileage/Pick-up and Drop-off Details**<br>• Transportation Log |
| 14 | **Laboratory, X-Ray, and Imaging Services** | • **Physician Order/Requisition Form, if required (*signed and dated*)**<br>• **Laboratory Report/Results**<br>• **Radiology/Imaging Report/Results and Interpretation (*please do not send X-Ray films*)** |
| 15 | **Outpatient Hospital Services:**<br>• Outpatient Services<br>• Emergency Services | • Admission Face Sheet/Coding Summary<br>• Admission History and Physical *(H and P) (signed and dated)*<br>• Discharge Summary *(signed and dated)*<br>• Physician Orders *(signed and dated)*<br>• Physician Progress Notes (*signed and dated*)<br>• Operative and Procedure Reports/Notes *(signed and dated) *required for all invasive procedures*<br>• Emergency Department Record/Notes *(signed and dated)*<br>• Nursing Assessment/Notes *(signed and dated)*<br>• Consultation Reports/Notes *(signed and dated)*<br>• Cardiovascular and Respiratory Reports *(signed and dated)* |

| Category | Type of Service | Documents Requested (if applicable to sampled claim) |
|---|---|---|
| | | • Laboratory and Diagnostic Tests/Reports<br>• Ambulance Services Transportation Record (*including mileage)*<br>• Medication Prescriptions/Orders *(signed and dated)*<br>• Infusion Service Notes<br>• Medication Administration Record *(MAR)*<br>• Anesthesia *(Pre- and Post-Op)* and Peri-operative Record/Notes *(signed and dated, including start and stop times, and total time spent for units billed, i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)*<br>• Physical and Occupational Therapy Assessments/Notes *(signed and dated, including start and stop times, and total time spent for units billed, i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)*<br>• Speech Language Pathology *(SLP)* Assessments/Notes *(signed and dated, including start and stop times, and total time spent for units billed, i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)*<br>• Labor and Delivery Record/Notes (*Please note: If a global obstetrician service is billed, please include perinatal/antepartum/peripartum/postpartum notes*) *(signed and dated)*<br>• All Transfer Forms *(signed and dated)*<br>• Dialysis Treatment Record/Notes *(signed and dated)*<br>• Itemized Billing Sheet (*if required based on payment method*) |
| 16 | **Durable Medical Equipment (DME) and Supplies, Prosthetic/ Orthopedic Devices, and Environmental Modifications** | • **Physician Orders (*signed and dated; include all relevant orders for the sampled claim*)**<br>• **Durable Medical Equipment/Supplies Prescription (*signed and dated*)**<br>• **Proof of Delivery/Signature Logs *(signed and dated)***<br>• **Total Time Spent for Units Billed *(i.e., 15 minutes, 30 minutes, 1 hour, 1 visit, etc.)***<br>• **Invoice for Services/Billed Item *(dated)***<br>• Prosthetic/Orthopedic Device Assessments/Notes *(signed and dated)*<br>• Detailed Product Description including Manufacturer, Brand, Model Number, and Item Description<br>• Certificate of Medical Necessity (*if applicable*) |
| 17 | **Transportation and Accommodations** | • **Starting Point and Destination/Odometer Readings**<br>• **Ground Mileage/Air Mileage Details**<br>• **Transportation Log with Beneficiary Signature**<br>• **Physician Order for Transportation/Accommodations *(signed and dated)* (*if applicable)***<br>• **Documentation reflecting Medical Necessity for Transportation and Accommodations**<br>• Emergency Medical Transportation Records with Documented Medical Necessity of Ambulance Transport *(if applicable)*<br>• Transportation Invoice<br>• Transportation/Accommodation Voucher Request Log *(if applicable)*<br>• Documentation such as receipts to Support Travel by Ferry/Bus/Taxi or application-based Transportation Network Company/Wheelchair Accessible Van, etc. *(if applicable)*<br>• Transportation Schedule for Requested Dates of Service<br>• Air Ambulance Flight Summary (*if billed on sampled claim*)<br>• Records for Beneficiary Care During Transport *(signed and dated)*<br>• Chaperone/Escort Documentation, if Appropriate *(approval/authorization if required)* |
| 18 | **Denied Claims** | No Documents/Medical Records Requested |
| 19 | **Crossover Claims** | No Documents/Medical Records Requested |
| 30 | **Capitated Care/Fixed Payments:**<br>• Fixed Payments for Primary Care Case Management (PCCM) | No Documents/Medical Records Requested |

| Category | Type of Service | Documents Requested (if applicable to sampled claim) |
|---|---|---|
| | • Medicare Part A Premiums<br>• Medicare Part B Premiums<br>• Health Insurance Premium Payments (HIPP)<br>• Aggregate Payments | |
| 50 | **Managed Care:**<br>• Capitated Payments to Health Maintenance Organization (HMO), Health Insurance Organization (HIO), or Program for All Inclusive Care for the Elderly (PACE) Plan<br>• Capitated Payments to Prepaid Health Plans (PHPs) | No Documents/Medical Records Requested |
| 99 | **Unknown** | Claim Data is Individually Reviewed for Category Determination |