PERM Review Contractor

RY 2022 Cycle 1 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 History and Physical (*H&P*) • Physician Orders and Progress Notes (*signed and dated*) • Medication Administration Record (*MAR*) • Discharge Summary • Admission Face Sheet/Coding Summary • Emergency Department Record and Admission Order/Notes • Nursing Assessment/Notes • Consultation Reports/Notes • Cardiovascular and Respiratory Reports • Itemized Billing Sheet (*if required based on payment method*) • ***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.*	• Ambulance Services • Dialysis Treatment Record/Notes • Operative and Procedure Reports/Notes • Anesthesia (*Pre- and Post-Op*) and Peri-operative Record/Notes (*with start and stop times*) • Laboratory and Diagnostic Tests/Reports • Labor and Delivery Record/Notes • All Transfer Forms • Physical Therapy: Evaluation/Re-evaluation/Notes • Speech Language Pathology: Evaluation/Re-evaluation/Notes • Occupational Therapy: Evaluation/Re-evaluation/Notes
2	**Psychiatric, Mental Health, and Behavioral Health Services:** • In/Outpatient Psychological, Psychiatric, and Behavioral Health Services • Drug and Alcohol In/Outpatient Svcs • Group Homes	• Clinic/Office Visit Record/Notes • Treatment Plan and Goals (*ISP, IPP, IFSP, POC in effect during sampled date(s) of service*) • Psychiatric Certification for Admission • 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*) • Medication Administration Record (*MAR*) • ***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.*	• Psychiatric Evaluation/Testing • Consultation Reports/Notes • Nursing Assessment, Flowsheets/Notes • 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.*) • Emergency Department Record/Notes • Evaluation and Management (*E&M*)/Counseling Notes • Admission Face Sheet/Coding Summary
3	**Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF):** • Nursing Home and Convalescent	• 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*)	• 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*) • Treatment Administration Record/Notes • All Transfer Forms • Leave-of-Absence Documentation

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	Centers • Chronic Care	• Documentation of Daily Patient Presence (*e.g., daily census, attendance log, etc.*) • Medication Administration Record (*MAR*) • ***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.*	• Nursing Assessment, Notes, and Flowsheets • Treatment Plan (*in effect during sampled date(s) of service*) • Admission Face Sheet
4	**Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes**	• Annual Physical Exam (*if required*) • Treatment Plan (*in effect during sampled date(s) of service*) • Documentation of Daily Patient Presence (*e.g., daily census, attendance log, etc.*) • Physician Orders (*signed and dated; include all orders relevant to sampled claim*) • Leave-of-Absence Documentation • ***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.*	• Progress Notes for All Disciplines • Medication Administration Record (*MAR*) • Treatment Administration Record/Notes • All Transfer Forms • Nursing Assessment, Notes, and Flowsheets • 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*) • Admission Face Sheet
5	**Clinic Services:** • Hospital-Based Clinics • Federally Qualified Health Centers (FQHC) • Indian Health Svcs (IHS) • Outpatient Rural Health Clinic (RHC)	• Encounter/Clinic Visit Record/Notes (*signed and dated*) • Clinic Face Sheet • Evaluation and Management (*E&M*)/Counseling Notes • Treatment Plan (*in effect during sampled date(s) of service*) • Nursing Notes • 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.*	• 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
6	**Physicians and Other Licensed Practitioners Services (*Includes***	• Encounter/Office Visit/Clinic Record/Notes (*signed and dated*) • Prenatal/Antepartum/Postpartum Record/Notes (*signed and dated*)	• Immunization Record • Medication Administration Record (*MAR*) • Dialysis Treatment Record/Notes

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	***APN, PA, Nurse Midwife, and Midwife*)**	• 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 • ***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.*	• Patient Education Documentation • Prior Authorization (*if required*) • Total Time Spent for Units Billed (*i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*)
7	**Dental and Oral Surgery Services**	• Dental or Orthodontic Clinical Notes (*signed and dated*) • Dental or Orthodontic Assessment • Dental Chart (*related to sampled date(s) of service*) • Dental or Orthodontic Plan of Care (*in effect during sampled date(s) of service*) • ***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.*	• Dental History • Dental X-Ray Notes (*please **do not** send x-rays*) • Procedure Record/Notes (*signed and dated*) • Prior Authorization (*if required*) • ***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).*
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*) • Documented Proof of Acceptance or Refusal of Counseling • Member Pharmacy Signature Log/Proof of Delivery • Member Profile with Refill History for the Sampled Medication • Proof of Delivery to SNF, NF, ICF, ICF/IID, or Personal Residence	• Prior Authorization (*if required*) • Signed Physician Medication Order for Skilled Nursing Facility (*SNF*)/Nursing Facility (*NF*) or Intermediate Care Facility (*ICF*) for Individuals with Intellectual Disabilities (*ICF/IID*) • Name of Drug, Dose, Route, Number Dispensed, and Number of Refills • NDC Number • ***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.*

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9	**Home Health Services:** • Home Health Agency Services • Medical Supplies, 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*) • Plan of Care (*in effect during sampled date(s) of service*) • Physician Orders (*signed and dated; include all physician orders relevant to sampled claim*) • Documentation of Face-to-Face Contact/Encounter with the Beneficiary • 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 and out*) • Physical Therapy (*PT*) Assessments and Progress Toward Goals (*time in and out*) • ***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.*	• Face-to-Face Encounter Record/Notes (*if required*) • Speech Therapy (*ST*) Assessments and Progress Toward Goals (*time in and out*) • Speech Language Pathology (*SLP*) Assessments and Progress Toward Goals (*time in and out*) • Occupational Therapy (*OT*) Assessments and Progress Toward Goals (*time in and out*) • Medical Supplies, Equipment, and Appliances Order/Prescription (*signed and dated*) • Medical Supplies, Equipment, and Appliances Signature Log/Proof of Delivery • Total Time Spent for Units Billed (*and unit identification, i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*) • Infusion Therapy, Medication/Fluid Name and Administration Specifics (*time in and out*)
10	**Personal Support Services:** • Personal Care Svcs ○ Qualified Service Provider, Personal Care Attendant, Aide, Homemaker Services, and Respite Care • Case Management/ Targeted Case Management Svcs • Private Duty Nursing • Meal Delivery Svcs	**Personal Care Services (*Qualified Service Provider, Personal Care Attendant, Aide, Homemaker Services, and Respite Care*):** • Timesheet, Completed and Signed (*include description of services approved and provided*) • Total Time Spent for Units Billed (*i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*) • Service/Treatment Plan and Goals (*in effect during sampled date(s) of service*) • Prior Authorization (*if required*) • Beneficiary's Signature/Proof-of-Service Receipt	• 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*)
		Case Management/Targeted Case Management Services: • Total Time Spent for Units Billed (*i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*) • Prior Authorization (*if required*) • Case Management Invoice/Billing/Timesheet	• Beneficiary's Signature/Proof-of-Service Receipt • Referral for Case Management/Statement of Necessity • Case Management Care Plan/Updates and Notes (*in effect during sampled date(s) of service; including telephonic contact*)

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		Private Duty Nursing: • Prior Authorization (*if required*) • Total Time Spent for Units Billed (*i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*) • 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 and signed with time in and time out*) • Beneficiary's Signature/Proof-of-Service Receipt
		Meal Delivery Services: • Meal Delivery Records/Signature Logs/Proof of Delivery • ***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.*	• Referral for Services • Prior Authorization (if required)
11	**Hospice Services:** • Services Provided at Home, Nursing Facility, Hospital, or Hospice Facility	• Hospice Nurse Visit and Progress Notes • 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 • ***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.*	• Initial/Intake Assessment • 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.*) • Admission Face Sheet
12	**Therapies, Hearing, Vision, and Rehabilitation Services: Physical, Occupational, Respiratory Therapies, Speech Language Pathology, Audiology, and Rehabilitation Services, Ophthalmology,**	• Orders (*signed and dated; include all physician or authorized relevant practitioner's orders related to sampled claim*) • Treatment Plan and Goals (*in effect during sampled date(s) of service*) • **Physical Therapy:** Evaluation/Re-evaluation/Notes (*signed and dated with start and stop times, and total time spent for units billed; i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*) • **Occupational Therapy:** Evaluation/Re-evaluation/Notes (*signed and dated with start and stop times, and total time spent for units billed; i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*)	• **Respiratory Therapy:** Evaluation/Re-evaluation/Notes (*signed and dated with start and stop times, and total time spent for units billed; i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*) • Durable Medical Equipment Receipt Signature Log/Proof of Delivery • Proof of Delivery/Signature Logs • Diagnostic Test Results • Ophthalmology Visit and Progress Notes (*signed and dated*) • Optometry and Optical Visit Notes (*signed and dated*) • Eyeglass/Optician Invoices

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	Optometry, and Optical Services, Necessary Supplies and Equipment	• **Speech Language Pathology:** Evaluation/Re-evaluation/Notes (*signed and dated with start and stop times, and total time spent for units billed; i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*) • **Audiology:** Evaluation/Re-evaluation/Notes (*signed and dated with start and stop times, and total time spent for units billed; i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*)	• Prior Authorization for Durable Medical Equipment Needed for Provision of Therapy Services (*if required*) • ***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.*
13	**Day Habilitation, Adult Day Care, Foster Care, or Waiver Programs and School-Based Services**	**Home and Community-Based Services (*HCBS*), Adult Day Care, Foster Care, or Waiver Services:** • Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (*signed and dated, with amount, type, start/stop times, and duration*) • Service/Treatment Plan and 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*) • ***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.*	• Case Management/Supervisory Visit Notes • DME Signature Log/Proof of Delivery • Prior Authorization (*if required*) • Orders from Identified Qualified Provider (*if required*) **Transportation Provider:** • Account Ledger and Billing Statements • Ground Mileage/Pick-up and Drop-off Details • Prior Authorization (*if required*)
		School-Based Services: • 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, include Physician Orders if required*) • Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (*signed and dated, with amount, type, start/stop times, and duration*) • Orders from Identified Qualified Provider • Psychological Testing, Mental Health Counseling Notes, Treatment Plan, and Progress Toward Goals • Case Management, Skilled Nursing, Social Work, and/or Personal Care Service	• Assistive Mobility, Vision, and/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*) • Service/Treatment Plan and Goals (*in effect during sampled date(s) of service*) **Transportation Provider:** • Account Ledger and Billing Statements • Ground Mileage/Pick-up and Drop-off Details

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		• ***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.*	
14	**Laboratory, X-Ray, and Imaging Services**	• Physician Order Sheet (*signed and dated*) • Laboratory Report/Results • Radiology/Imaging Report/Results and Interpretation (*please **do not** send x-rays*)	• ***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.*
15	**Outpatient Hospital Services:** • Outpatient • Emergency Svcs	• Operative and Procedure Reports/Notes • Emergency Department Record/Notes • Physician Orders and Progress Notes (*signed and dated*) • Admission Face Sheet/Coding Summary • Admission History and Physical (*H&P*) • Nursing Assessment/Notes • Consultation Reports/Notes • Cardiovascular and Respiratory Reports • Physical and Occupational Therapy Assessments/Notes • Speech Language Pathology (*SLP*) Assessments/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.*	• Ambulance Services • Medication Administration Record (*MAR*) • Dialysis Treatment Record/Notes • Anesthesia (*Pre- and Post-Op*) and Peri-operative Record/Notes (*with start and stop times*) • Laboratory and 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) and Supplies, Prosthetic/ Orthopedic Devices, and Environmental Modifications**	• Physician Orders (*signed and dated; include all relevant orders for the sampled claim*) • Durable Medical Equipment/Supplies Prescription (*signed and dated*) • Proof of Delivery/Signature Logs (*dated*) • Prior Authorization for Devices, Prosthetics, Equipment, Environmental Modifications, and/or Supplies (*if required*)	• Prosthetic/Orthopedic Device Assessments/Notes (*dated*) • Invoice for Services (*dated*) • Total Time Spent for Units Billed (*i.e., 15 min., 30 min., 1 hr., 1 visit, etc.*) • ***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.*

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17	**Transportation and Accommodations**	• Emergency Medical Transportation Records with Documented Medical Necessity of Ambulance Transport (*if applicable*) • Ground Mileage/Air Mileage Details • Starting Point and Destination/Odometer Readings • Transportation Log with Member Signature • ***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.*	• Transportation Schedule for Requested Dates of Service • 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	

Category	Type of Service	Documents Requested (if applicable to sampled claim)
99	**Unknown**	Claim Data is Individually Reviewed for Category Determination