

PERM Review Contractor  
FY 2016 Cycle 2 Claim Category Matrix

Category	Type of Service	Documents Requested (If applicable to sampled claim)	
1	<b>Inpatient Hospital Services:</b> <ul style="list-style-type: none"> <li>• Acute Inpatient</li> <li>• Long Term Acute</li> <li>• Acute Inpatient Rehabilitation</li> </ul>	<ul style="list-style-type: none"> <li>• Admission Face Sheet / Coding Summary</li> <li>• Physician Coding Query Forms</li> <li>• Emergency Department Record &amp; Admit / Notes</li> <li>• Admission History &amp; Physical (H&amp;P)</li> <li>• Physician Orders &amp; Progress Notes (<i>signed and dated</i>)</li> <li>• Nursing Assessment / Notes</li> <li>• Consultation Reports / Notes</li> <li>• Cardiovascular&amp; Respiratory Reports</li> <li>• Speech Language Pathology: Evaluation/Re-evaluation/Notes (<i>signed &amp; dated with start /stop times, &amp; total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.</i>)</li> <li>• Physical Therapy: Evaluation/Re-evaluation/Notes (<i>signed &amp; dated with start &amp; stop times, &amp; total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Occupational Therapy: Evaluation/Re-evaluation/Notes (<i>signed &amp; dated with start &amp; stop times, &amp; total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.</i>)</li> <li>• Ambulance Services</li> <li>• Medication Administration Record (MAR)</li> <li>• Dialysis Record / Notes</li> <li>• Operative &amp; Procedure Reports / Notes</li> <li>• Anesthesia (<i>Pre and Post-Op</i>) &amp; Peri-operative Record / Notes (<i>with start and stop times</i>)</li> <li>• Laboratory &amp; Diagnostic Tests / Reports</li> <li>• Labor and Delivery Record / Notes</li> <li>• Discharge Summary</li> <li>• All Transfer Forms</li> <li>• Itemized billing sheet (<i>if required based on payment method</i>)</li> </ul>
2	<b>Psychiatric, Mental, &amp; Behavioral Health:</b> <ul style="list-style-type: none"> <li>• In/Outpatient Psychological, Psychiatric, and Behavioral Health Services</li> <li>• Drug and Alcohol In/Outpatient Svcs</li> <li>• Group Homes</li> </ul>	<ul style="list-style-type: none"> <li>• Admission Face Sheet / Coding Summary</li> <li>• Physician Coding Query Forms</li> <li>• Psychiatric Certification for Admission</li> <li>• Emergency Department Record / Notes</li> <li>• Clinic / Office Visit Record / Notes</li> <li>• Evaluation &amp; Management (E&amp;M) / Counseling Notes</li> <li>• Admission History and Physical (H&amp;P)</li> <li>• Physician Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</li> <li>• Mental Health Progress / Therapy Notes / Daily Attendance Logs (<i>with start and stop times</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatric Evaluation / Testing</li> <li>• Treatment Plan &amp; Goals (<i>ISP, IPP, IFSP, POC, in effect during sampled date/s of service</i>)</li> <li>• Consultation Reports / Notes</li> <li>• Nursing Assessment, Flowsheets/Notes</li> <li>• Medication Administration Record (MAR)</li> <li>• Treatment Administration Record / Notes</li> <li>• Discharge Summary</li> <li>• All Transfer Forms: <i>Voluntary, Involuntary, or Court Ordered</i></li> <li>• Documentation of daily patient presence (<i>e.g. daily census, attendance log, etc.</i>)</li> </ul>
3	<b>Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF):</b> <ul style="list-style-type: none"> <li>• Nursing Home and Convalescent Centers</li> <li>• Chronic Care</li> </ul>	<ul style="list-style-type: none"> <li>• Admission Face Sheet</li> <li>• Physician Certification / Recertification (<i>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</i>)</li> <li>• Physician Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</li> <li>• Progress Notes for All Disciplines / Department (<i>to include physician's 60 day progress notes in effect during sampled date/s of service</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Medication Administration Record (MAR)</li> <li>• Treatment Administration Record / Notes</li> <li>• Documentation of daily patient presence (<i>e.g. daily census, attendance log, etc.</i>)</li> <li>• All Transfer Forms</li> <li>• Leave of Absence Documentation</li> <li>• Nursing Assessment, Notes, &amp; Flowsheets</li> <li>• Treatment Plan (<i>in effect during sampled date/s of service</i>)</li> </ul>

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4	<b>Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes</b>	<ul style="list-style-type: none"> <li>• Admission Face Sheet</li> <li>• Physician Certification / Recertification (<i>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</i>)</li> <li>• Physician Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</li> <li>• Progress Notes for All Disciplines / Departments (<i>to include physician's 60 day progress notes in effect during sampled date/s of service</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Medication Administration Record (<i>MAR</i>)</li> <li>• Treatment Administration Record / Notes</li> <li>• Documentation of daily patient presence (<i>e.g. daily census, attendance log, etc.</i>)</li> <li>• All Transfer Forms</li> <li>• Leave of Absence Documentation</li> <li>• Nursing Assessment, Notes, &amp; Flowsheets</li> <li>• Annual physical exam (<i>if required</i>)</li> <li>• Treatment Plan (<i>in effect during sampled date/s of service</i>)</li> </ul>
5	<b>Clinic Services:</b> <ul style="list-style-type: none"> <li>• Hospital based clinics</li> <li>• Federally Qualified Health Centers (FQHC)</li> <li>• Indian Health Svcs</li> <li>• Outpatient Rural Health Clinic (RHC)</li> </ul>	<ul style="list-style-type: none"> <li>• Clinic Face Sheet</li> <li>• Encounter / Clinic Visit Record / Notes (<i>signed and dated</i>)</li> <li>• Evaluation and Management (<i>E&amp;M</i>) / Counseling Notes</li> <li>• Treatment Plan (<i>in effect during sampled date/s of service</i>)</li> <li>• Dialysis Treatment Record / Notes</li> </ul>	<ul style="list-style-type: none"> <li>• Related Laboratory / Diagnostic Reports</li> <li>• Physician Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</li> <li>• Pharmacy Services and Medication Administration Record (<i>MAR</i>)</li> <li>• Dental and Diagnostic Service Records</li> <li>• Immunization Record</li> <li>• Nursing Notes</li> </ul>
6	<b>Physicians &amp; other Licensed Practitioners Services (Includes APN, PA, Nurse Midwife &amp; Midwife)</b>	<b>Physician &amp; Other Licensed Practitioners Services:</b> <ul style="list-style-type: none"> <li>• Encounter/ Office Visit / Clinic Record &amp; Notes (<i>signed and dated</i>)</li> <li>• Evaluation and Management (<i>E&amp;M</i>) /Counseling Notes (<i>signed and dated</i>)</li> <li>• Related Laboratory / Diagnostic Reports</li> <li>• Treatment Plan (<i>in effect during sampled date/s of service</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Procedure Record / Notes</li> <li>• Immunization Record</li> <li>• Medication Administration Record (<i>MAR</i>)</li> <li>• Dialysis Treatment Records and Notes</li> <li>• Patient Education Documentation</li> <li>• Prior Authorization (<i>if required</i>)</li> <li>• Total Time Spent for Units Billed (<i>i.e. 15 min., 30 min., 1 hr., 1 visit, etc.</i>)</li> </ul>

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7	<b>Dental &amp; Oral Surgery Services</b>	<p><b>Dental &amp; Oral Surgery Services:</b></p> <ul style="list-style-type: none"> <li>• Dental or Orthodontic Assessment</li> <li>• Dental Chart (<i>related to sampled date/s of service</i>)</li> <li>• Dental or Orthodontic Clinical Notes (<i>signed and dated</i>)</li> <li>• Dental or Orthodontic Plan of Care (<i>in effect during sampled date/s of service</i>)</li> </ul> <p><b>Note:</b> <i>Clinical Documentation (notes, plan of care, etc.) issued from electronic records must be signed and dated (electronic signature acceptable if permitted by state regulations).</i></p>	<ul style="list-style-type: none"> <li>• Dental History</li> <li>• Dental X-Ray Notes (<i>please do not send x-rays</i>)</li> <li>• Procedure Record / Notes (<i>signed and dated</i>)</li> <li>• Prior Authorization (<i>if required</i>)</li> </ul>
8	<b>Prescribed Drugs</b>	<ul style="list-style-type: none"> <li>• Copy of Prescription in Original, Facsimile, Telephonic, or Electronic form: Front and Back (<i>if applicable</i>)—with patient name, date of birth, address, telephone number, physician name, &amp; signature (<i>signature method as required/permitted by state regulations</i>)</li> <li>• Name of Drug, Dose, Route, Number Dispensed, &amp; Number of Refills</li> <li>• NDC Number</li> </ul>	<ul style="list-style-type: none"> <li>• Prior Authorization (<i>if required</i>)</li> <li>• Member Pharmacy Signature Log / Proof of Delivery</li> <li>• Documented proof of acceptance or refusal of counseling</li> <li>• Signed Physician Medication Order for Skilled Nursing Facility (<i>SNF</i>) / Nursing Facility (<i>NF</i>) or Intermediate Care Facility (<i>ICF</i>) for Persons with Mental Retardation (<i>ICF/MR</i>)</li> <li>• Proof of Delivery to SNF, NF, ICF, ICF/MR or personal residence</li> <li>• Member Profile with Refill History for the <u>sampled medication</u></li> </ul>
9	<p><b>Home Health Services:</b></p> <ul style="list-style-type: none"> <li>• Home Health Agency Services &amp; Medical Supplies</li> <li>• Equipment and Appliances through the Agency</li> </ul>	<p><b>Home Health Services:</b></p> <ul style="list-style-type: none"> <li>• Physician Certification/Recertification (<i>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</i>)</li> <li>• Plan of Care (<i>in effect during sampled date/s of service</i>)</li> <li>• Physician Orders (<i>signed and dated; include all physician orders relevant to sampled claim</i>)</li> <li>• Initial / Intake Assessment</li> <li>• Nursing Assessments and Notes</li> <li>• Nursing Care Plan/Treatment Care Plan (<i>in effect during sampled date/s of service</i>)</li> <li>• Home Health Aide Notes / Worksheets (<i>time in &amp; out</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Physical Therapy (<i>PT</i>) Assessments &amp; progress toward goals (<i>time in &amp; out</i>)</li> <li>• Speech Therapy (<i>ST</i>) Assessments &amp; progress toward goals (<i>time in &amp; out</i>)</li> <li>• Speech Language Pathology (<i>SLP</i>) Assessments &amp; progress toward goals (<i>time in &amp; out</i>)</li> <li>• Occupational Therapy (<i>OT</i>) Assessments &amp; progress toward goals (<i>time in &amp; out</i>)</li> <li>• DME Order/Prescription (<i>signed and dated</i>)</li> <li>• DME Signature Log/Proof of Delivery</li> <li>• Total Time Spent for Units Billed (<i>&amp; unit identification i.e. 15 min., 30 min., 1 hr., 1 visit, etc.</i>)</li> <li>• Infusion Therapy, medication/fluid name &amp; administration specifics (<i>time in &amp; out</i>)</li> <li>• Face to Face forms (<i>if required</i>)</li> </ul>

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10	<b>Personal Support Services:</b> <ul style="list-style-type: none"> <li>• Personal Care Svcs Personal Care               <ul style="list-style-type: none"> <li>• Personal Care Attendant, Aide, Homemaker Services, &amp; Respite Care</li> </ul> </li> <li>• Targeted Case Management Svcs</li> <li>• Private Duty Nursing</li> <li>• Meal Delivery Svcs</li> </ul>	<b>Personal Care Services (Qualified Service Provider, Personal Care Attendant, Aide, Homemaker services &amp; Respite Care):</b> <ul style="list-style-type: none"> <li>• Physician Certification / Recertification (<i>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</i>)</li> <li>• Statement of Medical Necessity</li> <li>• Physician Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Initial Intake Assessment / Reassessment (<i>as relevant to dates of service</i>)</li> <li>• Timesheet, completed &amp; signed (<i>include description of services approved &amp; provided</i>)</li> <li>• Recipient's signature / proof of service receipt</li> <li>• Total Time Spent for Units Billed (<i>i.e. 15 min., 30 min., 1 hr., 1 visit, etc.</i>)</li> </ul>
		<b>Case Management/Targeted Case Management Services:</b> <ul style="list-style-type: none"> <li>• Referral for Case Management / Statement of Necessity</li> <li>• Case Management Care Plan / Updates &amp; Notes (<i>in effect during sampled date/s of service; including telephonic contact</i>)</li> <li>• Goals / Timelines / Outcome Measures (<i>with description of services approved &amp; provided</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Case Management Invoice / Billing / Timesheet</li> <li>• Recipient's signature / proof of service receipt</li> <li>• Total Time Spent for Units Billed (<i>i.e. 15 min., 30 min., 1 hr., 1 visit, etc.</i>)</li> </ul>
		<b>Private Duty Nursing:</b> <ul style="list-style-type: none"> <li>• Physician Orders / Statement of Medical Necessity (<i>signed and dated; include all physician orders relevant to sampled claim</i>)</li> <li>• Initial / Intake Assessment / Reassessment</li> </ul>	<ul style="list-style-type: none"> <li>• Nursing Flowsheets/Notes (<i>completed &amp; signed with time in &amp; out</i>)</li> <li>• Recipient's signature / proof of service receipt</li> <li>• Total Time Spent for Units Billed (<i>i.e. 15 min., 30 min., 1 hr., 1 visit, etc.</i>)</li> </ul>
		<b>Meal Delivery Services:</b> <ul style="list-style-type: none"> <li>• Referral for Services</li> <li>• Meal Delivery Records / Signature Logs / Proof of Delivery</li> </ul>	
11	<b>Hospice Services:</b> <ul style="list-style-type: none"> <li>• Services provided at Home, Nursing Facility, Hospital, or Hospice Facility</li> </ul>	<b>Hospice Services:</b> <ul style="list-style-type: none"> <li>• Admission Face Sheet</li> <li>• Physician Certification / Recertification (<i>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</i>)</li> <li>• Physician's Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</li> <li>• Hospice Benefit Election / Revocation Forms</li> </ul>	<ul style="list-style-type: none"> <li>• Initial / Intake Assessment</li> <li>• Hospice Nurse Visit and Progress Notes</li> <li>• Multidisciplinary Care Plan and Notes (<i>in effect during sampled date/s of service</i>)</li> <li>• Social Work Notes</li> <li>• Home Health Aide Notes / Worksheets</li> <li>• Medication Administration Record (<i>MAR</i>)</li> <li>• Documentation of daily patient presence (<i>e.g. daily census, attendance log, etc.</i>)</li> </ul>

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12	<b>Physical, Occupational, Respiratory Therapies, Speech Language Pathology, Audiology, &amp; Rehabilitation Services, Ophthalmology, Optometry, &amp; Optical Services Necessary Supplies &amp; Equipment</b>	<b>Physical, Occupational, Respiratory, Speech Language Pathology, Audiology, &amp; Rehabilitation Services, Ophthalmology, Optometry, &amp; Optical Services, Necessary Supplies &amp; Equipment</b> <ul style="list-style-type: none"> <li>• Orders (signed and dated; include all physician or authorized relevant practitioner's orders related to sampled claim)</li> <li>• Treatment Plan &amp; Goals (in effect during sampled date/s of service)</li> <li>• Physical Therapy: Evaluation / Re-evaluation / Notes (signed &amp; dated with start &amp; stop times, &amp; total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)</li> <li>• Occupational Therapy: Evaluation/ Re-evaluation/Notes (signed &amp; dated with start &amp; stop times, &amp; total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)</li> <li>• Speech Language Pathology: Evaluation/Re-evaluation/Notes (signed &amp; dated with start /stop times, &amp; total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Audiology: Evaluation / Re-evaluation / Notes (signed &amp; dated with start &amp; stop times, &amp; total time spent for units billed i.e., 15 min, 30 min, 1hr, 1 visit, etc.)</li> <li>• Respiratory Therapy: Evaluation and Re-evaluation / Notes (signed &amp; dated with start &amp; stop times, &amp; total time spent for units billed i.e., 15 min, 30 min, 1hr, 1 visit, etc.)</li> <li>• Prior Authorization for Durable Medical Equipment needed for provision of therapy services (if required)</li> <li>• Durable Medical Equipment Receipt Signature Log / Proof of Delivery</li> <li>• Diagnostic Test Results</li> <li>• Ophthalmology Visit and Progress Notes (signed and dated)</li> <li>• Optometry and Optical Visit Notes (signed and dated)</li> <li>• Eyeglass / Optician Invoices</li> <li>• Proof of Delivery / Signature Logs</li> </ul>
13	<b>Day Habilitation, Adult Day Care, Foster Care, or Waiver Programs &amp; School Based Services</b>	<b>Home and Community Based Services (HCBS), Adult Day Care, Foster Care, or Waiver Services:</b> <ul style="list-style-type: none"> <li>• Orders from identified qualified provider (if required)</li> <li>• Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (signed and dated, with amount, type, start/stop times, and duration)</li> <li>• Service/Treatment Plan &amp; Goals (in effect during sampled date/s of service)</li> <li>• 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)</li> </ul>	<ul style="list-style-type: none"> <li>• Case Management / Supervisory Visit Notes</li> <li>• DME Signature Log / Proof of Delivery</li> </ul> <p>Transportation Provider:</p> <ul style="list-style-type: none"> <li>• Account Ledger and Billing Statements</li> <li>• Ground Mileage / Pick-up &amp; Drop Off Details</li> </ul>

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		<p><b>School Based Services:</b></p> <ul style="list-style-type: none"> <li>• Orders from identified qualified provider</li> <li>• Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, &amp; Records (<i>signed and dated, with amount, type, start/stop times, and duration</i>)</li> <li>• Psychological Testing, Mental Health counseling notes, treatment plan, &amp; progress toward goals</li> <li>• Case Management, Skilled Nursing, Social Work, &amp;/or Personal Care Service</li> <li>• Service/Treatment Plan &amp; Goals (<i>in effect during sampled date/s of service</i>)</li> <li>• Individual Education Plan (<i>IEP</i>); Individual Program Plan (<i>IPP</i>); Individual Service Plan (<i>ISP</i>); Individual Family Service Plan (<i>IFSP</i>) (<i>in effect during sampled date/s of service</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Assistive Mobility, Vision, &amp;/or Hearing Technology Device</li> <li>• Deaf Interpreter or Sign Language Service</li> <li>• PT, OT, SLP, Audiology, Vision, and Respiratory Therapy (<i>RT</i>): Evaluation and Re-evaluation/Notes</li> <li>• Medication Administration Record (<i>MAR</i>)</li> </ul> <p>Transportation Provider:</p> <ul style="list-style-type: none"> <li>• Account Ledger and Billing Statements</li> <li>• Ground Mileage / Pick-up &amp; Drop Off Details</li> </ul>
Category	Type of Service	Documents Requested (If applicable to sampled claim)	
14	<b>Laboratory, X-ray &amp; Imaging Services</b>	<p><b>Laboratory, X-ray, &amp; Imaging Services:</b></p> <ul style="list-style-type: none"> <li>• Physician Order Sheet (<i>signed and dated</i>)</li> <li>• Laboratory Report / Results</li> </ul>	<ul style="list-style-type: none"> <li>• Radiology / Imaging Report / Results &amp; Interpretation (<i>please do not send x-rays</i>)</li> </ul>
15	<p><b>Outpatient Hospital Services:</b></p> <ul style="list-style-type: none"> <li>• Outpatient</li> <li>• Emergency Svcs</li> </ul>	<p><b>Outpatient Hospital Services:</b></p> <ul style="list-style-type: none"> <li>• Admission Face Sheet / Coding Summary</li> <li>• Physician Coding Query Forms</li> <li>• Emergency Department Record / Notes</li> <li>• Admission History &amp; Physical (<i>H&amp;P</i>)</li> <li>• Physician Orders &amp; Progress Notes (<i>signed and dated</i>)</li> <li>• Nursing Assessment / Notes</li> <li>• Consultation Reports / Notes</li> <li>• Cardiovascular &amp; Respiratory Reports</li> <li>• Physical &amp; Occupational Therapy Assessments / Notes</li> <li>• Speech Language Pathology (<i>SLP</i>) Assessments / Notes</li> <li>• Ambulance Services</li> </ul>	<ul style="list-style-type: none"> <li>• Medication Administration Record (<i>MAR</i>)</li> <li>• Dialysis Record / Notes</li> <li>• Operative &amp; Procedure Reports / Notes</li> <li>• Anesthesia (Pre and Post-Op) &amp; Peri-operative Record / Notes (<i>with start and stop times</i>)</li> <li>• Laboratory &amp; Diagnostic Tests / Reports</li> <li>• Labor and Delivery Record / Notes</li> <li>• Discharge Summary</li> <li>• All Transfer Forms</li> <li>• Itemized billing sheet (<i>if required based on payment method</i>)</li> </ul>
16	<b>Durable Medical Equipment (DME) &amp; Supplies, Prosthetic / Orthopedic Devices, &amp; Environmental Modifications</b>	<p><b>Durable Medical Equipment, Supplies, Prosthetic Devices, &amp; Environmental Modifications:</b></p> <ul style="list-style-type: none"> <li>• Physician Orders (<i>signed and dated; include all relevant orders for the sampled claim</i>)</li> <li>• Durable Medical Equipment / Supplies Prescription (<i>signed and dated</i>)</li> <li>• Prosthetic / Orthopedic Device Assessments / Notes (<i>dated</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Proof of Delivery / Signature Logs (<i>dated</i>)</li> <li>• Prior Authorization for Devices, Prosthetics, Equipment, Environmental Modifications, &amp;/or Supplies (<i>if required</i>)</li> <li>• Invoice for Services (<i>dated</i>)</li> <li>• Total Time Spent for Units Billed (<i>i.e. 15 min., 30 min., 1 hr., 1 visit, etc.</i>)</li> </ul>

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17	<b>Transportation &amp; Accommodations</b>	<p><b>Transportation &amp; Accommodations:</b></p> <ul style="list-style-type: none"> <li>• Emergency Medical Transportation Records with documented medical necessity of Ambulance transport <i>(if applicable)</i></li> <li>• Transportation Schedule for requested dates of service</li> <li>• Starting Point and Destination / Odometer Readings</li> <li>• Transportation Log with Member Signature</li> </ul> <ul style="list-style-type: none"> <li>• Ground Mileage / Air Mileage Details</li> <li>• Physician Order for Transportation / Accommodations <i>(if applicable)</i></li> <li>• Documentation reflecting Medical Necessity for Transportation and Accommodations</li> <li>• Chaperone Documentation, if appropriate <i>(approval/authorization)</i></li> </ul>
18	<b>Denied Claims</b>	No Documents / Medical Records Requested
19	<b>Crossover Claims</b>	No Documents / Medical Records Requested
30	<p><b>Capitated Care/Fixed Payments</b></p> <ul style="list-style-type: none"> <li>• Fixed Payments for Primary Care</li> <li>• Case Management (PCCM)</li> <li>• Medicare Part A Premiums</li> <li>• Medicare Part B Premiums</li> <li>• Health Insurance Premium Payments (HIPP)</li> <li>• Aggregate Payments</li> </ul>	No Documents / Medical Records Requested
50	<p><b>Managed Care</b></p> <ul style="list-style-type: none"> <li>• Capitated Payments to HMO, HIO, or PACE Plan</li> <li>• Capitated Payments to Prepaid Health Plans (PHPs)</li> </ul>	No Documents / Medical Records Requested
99	<b>UNKNOWN</b>	Claim Data is Individually Reviewed for Category Determination