## Category 1: Inpatient Hospital Services
- **Acute Inpatient**
- **Long Term Acute**
- **Acute Inpatient Rehabilitation**

### Type of Service: Inpatient Hospital Services
- 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, 1 hr, 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, 1 hr, 1 visit, etc.)*

### Documents Requested (If applicable to sampled claim):
- Occupational Therapy: Evaluation/Re-evaluation/Notes *(signed & dated with start & stop times, & total time spent for units billed i.e. 15 min, 30 min, 1 hr, 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)*

## Category 2: Psychiatric, Mental, & Behavioral Health
- **In/Outpatient Psychological, Psychiatric, and Behavioral Health Services**
- **Drug and Alcohol In/Outpatient Svcs**
- **Group Homes**

### Type of Service: Psychiatric, Mental, & Behavioral Health
- 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)*

### Documents Requested (If applicable to sampled claim):
- 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.)*

## Category 3: Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF):
- **Nursing Home and Convalescent Centers**
- **Chronic Care**

### Type of Service: Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF)
- 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)*

### Documents Requested (If applicable to sampled claim):
- 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)*
<table>
<thead>
<tr>
<th>Category</th>
<th>Type of Service</th>
<th>Documents Requested (If applicable to sampled claim)</th>
</tr>
</thead>
</table>
| 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.)* |
# FY 2016 Cycle 2 Claim Category Matrix

## Category 7
### Dental & Oral Surgery Services
- **Documents Requested (If applicable to sampled claim):**
  - 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).*

## Category 8
### Prescribed Drugs
- **Documents Requested (If applicable to sampled claim):**
  - 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 Persons with Mental Retardation *(ICF/MR)*
  - Proof of Delivery to SNF, NF, ICF, ICF/MR or personal residence
  - Member Profile with Refill History for the sampled medication

## Category 9
### Home Health Services:
- **Documents Requested (If applicable to sampled claim):**
  - 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)*
<table>
<thead>
<tr>
<th>Category</th>
<th>Type of Service</th>
<th>Documents Requested (If applicable to sampled claim)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Personal Support Services:</td>
<td>Personal Care Services <em>(Qualified Service Provider, Personal Care Attendant, Aide, Homemaker services &amp; Respite Care)</em>:</td>
</tr>
<tr>
<td></td>
<td>Personal Care Svcs Personal Care</td>
<td>• Physician Certification / Recertification <em>(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)</em></td>
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<tr>
<td></td>
<td>Personal Care Attendant, Aide, Homemaker Services, &amp; Respite Care</td>
<td>• Statement of Medical Necessity</td>
</tr>
<tr>
<td></td>
<td>Targeted Case Management Svcs</td>
<td>• Physician Orders <em>(signed and dated; include all orders relevant to sampled claim)</em></td>
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<tr>
<td></td>
<td>Private Duty Nursing</td>
<td>• Initial Intake Assessment / Reassessment <em>(as relevant to dates of service)</em></td>
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<td></td>
<td>Meal Delivery Svcs</td>
<td>• Timesheet, completed &amp; signed <em>(include description of services approved &amp; provided)</em></td>
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<td>• Recipient’s signature / proof of service receipt</td>
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<td>• Total Time Spent for Units Billed <em>(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)</em></td>
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<td></td>
<td><strong>Case Management/Targeted Case Management Services:</strong></td>
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<td></td>
<td>• Referral for Case Management / Statement of Necessity</td>
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<td>• Case Management Care Plan / Updates &amp; Notes <em>(in effect during sampled date/s of service; including telephonic contact)</em></td>
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<td>• Goals / Timelines / Outcome Measures <em>(with description of services approved &amp; provided)</em></td>
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<td></td>
<td></td>
<td>• Case Management Invoice / Billing / Timesheet</td>
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<td>• Initial / Intake Assessment / Reassessment</td>
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<td>• Nursing Flowsheets/Notes <em>(completed &amp; signed with time in &amp; out)</em></td>
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<td>• Recipient’s signature / proof of service receipt</td>
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<td><strong>Meal Delivery Services:</strong></td>
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<td>• Referral for Services</td>
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<td>• Meal Delivery Records / Signature Logs / Proof of Delivery</td>
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</tbody>
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<tbody>
<tr>
<td>11</td>
<td>Hospice Services:</td>
<td>Hospice Services:</td>
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<tr>
<td></td>
<td>Services provided at Home, Nursing Facility, Hospital, or Hospice Facility</td>
<td>• Admission Face Sheet</td>
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<td>Physician Certification / Recertification <em>(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)</em></td>
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<td>Physician’s Orders <em>(signed and dated; include all orders relevant to sampled claim)</em></td>
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<td>Hospice Benefit Election / Revocation Forms</td>
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<td>• Initial / Intake Assessment</td>
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<td></td>
<td>Hospice Nurse Visit and Progress Notes</td>
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<td>Multidisciplinary Care Plan and Notes <em>(in effect during sampled date/s of service)</em></td>
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<td>Social Work Notes</td>
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<td>Home Health Aide Notes / Worksheets</td>
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<td>Medication Administration Record <em>(MAR)</em></td>
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<tr>
<td>12</td>
<td>Physical, Occupational, Respiratory, Speech Language Pathology, Audiology, &amp; Rehabilitation Services, Ophthalmology, Optometry, &amp; Optical Services, Necessary Supplies &amp; Equipment</td>
<td>- Orders (signed and dated; include all physician or authorized relevant practitioner's orders related to sampled claim)&lt;br&gt;- Treatment Plan &amp; Goals (in effect during sampled date/s of service)&lt;br&gt;- 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, 1 hr, 1 visit, etc.)&lt;br&gt;- 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, 1 hr, 1 visit, etc.)&lt;br&gt;- 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, 1 hr, 1 visit, etc.)&lt;br&gt;- 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, 1 hr, 1 visit, etc.)&lt;br&gt;- 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, 1 hr, 1 visit, etc.)&lt;br&gt;- Prior Authorization for Durable Medical Equipment needed for provision of therapy services (if required)&lt;br&gt;- Durable Medical Equipment Receipt Signature Log / Proof of Delivery&lt;br&gt;- Diagnostic Test Results&lt;br&gt;- Ophthalmology Visit and Progress Notes (signed and dated)&lt;br&gt;- Optometry and Optical Visit Notes (signed and dated)&lt;br&gt;- Eyeglass / Optician Invoices&lt;br&gt;- Proof of Delivery / Signature Logs</td>
</tr>
<tr>
<td>13</td>
<td>Day Habilitation, Adult Day Care, Foster Care, or Waiver Programs &amp; School Based Services</td>
<td>- Orders from identified qualified provider (if required)&lt;br&gt;- Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (signed and dated, with amount, type, start/stop times, and duration)&lt;br&gt;- Service/Treatment Plan &amp; Goals (in effect during sampled date/s of service)&lt;br&gt;- 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)&lt;br&gt;- Case Management / Supervisory Visit Notes&lt;br&gt;- DME Signature Log / Proof of Delivery&lt;br&gt;- Transportation Provider:&lt;br&gt;- Account Ledger and Billing Statements&lt;br&gt;- Ground Mileage / Pick-up &amp; Drop Off Details</td>
</tr>
</tbody>
</table>
## 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.)*
<table>
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<tr>
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</table>
| 17       | 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 | No Documents / Medical Records Requested                                                                            |
| 50       | Managed Care                 | No Documents / Medical Records Requested                                                                            |
| 99       | UNKNOWN                      | Claim Data is Individually Reviewed for Category Determination                                                    |