



Reimbursement Policy

Subject: Documentation Standards for Episodes of Care

Effective Date: 03/19/15	Committee Approval Obtained: 11/06/20	Section: Administration
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*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to <https://providers.amerigroup.com>.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s Amerigroup Medicare Advantage benefit plan. The determination that a service, procedure, item, etc. is covered under a member’s benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member’s state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup Medicare Advantage requires that documentation for all episodes of care must meet the following criteria unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise:
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- Documentation must be legible to someone other than the writer.
- Documentation must be complete, dated and timed.
- Documentation must reflect all aspects of care.
- Information identifying the member must be included on each page in the medical record.
- Each entry in the medical record must include author identification, which may be a handwritten signature, unique electronic identifier or initials.

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements when applicable:

- Member identifying information
- Consent forms
- Health history, including applicable drug allergies
- Physical examinations
- Physician orders
- Immunization records
- Medications prescribed
- Emergency care
- Smoking, alcohol and substance abuse history
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered, appropriate to member's age and health status
- Evidence of coordination of care between primary and specialty physicians
- Working diagnoses consistent with findings and test results
- Treatment plans consistent with diagnoses
- Recorded start and stop times for time based procedures

Note: Documentation should support the procedure and modifier(s) usage. Depending on the episode of care, more specific documentation, in compliance with federal and state regulations, may be required for the medical record to be considered complete.

	<p>Providers should refer to standard data elements to be included for specific episodes of care as established by The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations.</p> <p>Other Documentation Not Directly Related to the Member Other documentation not directly related to the member, but relevant to support clinical practice, may be used to support documentation regarding episodes of care, including:</p> <ul style="list-style-type: none"> • Policies, procedures and protocols. • Critical incident/occupational health and safety reports. • Statistical and research data. • Clinical assessments. • Published reports/data. <p>Amerigroup Medicare Advantage may request that providers submit additional documentation, including medical records or other documentation not directly related to the member, to support claims submitted by the provider. If documentation is not provided following the request or notification, or if documentation does not support the services billed for the episode of care, Amerigroup Medicare Advantage may:</p> <ul style="list-style-type: none"> • Deny the claim. • Recover and/or recoup monies previously paid on the claim. <p>Amerigroup Medicare Advantage is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.</p>
<p>History</p>	<ul style="list-style-type: none"> • Biennial review approved 11/06/20: Minor administrative updates • Biennial review approved 05/01/17: Policy language updated; Policy template updated • Biennial review approved and effective 03/19/15: Policy language updated; policy template updated • Initial review approved and effective 01/01/15
<p>References and Research Materials</p>	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • CMS • State contracts • CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services • The Joint Commission
<p>Definitions</p>	<ul style="list-style-type: none"> • Episode of Care: a single episode of care refers to continuous care or a series of intervals of brief separations from care to a member

	<p>by a provider or facility for the same specific medical problem or condition</p> <ul style="list-style-type: none"> • General Reimbursement Policy Definitions
Related Policies	<ul style="list-style-type: none"> • Claims Requiring Additional Documentation • Claims Submission — Required Information for Facilities • Claims Submission — Required Information for Professional Providers
Related Materials	<ul style="list-style-type: none"> • None