



		Reimbursement Policy
Subject: Documentation Standards for Episodes of Care		
Effective Date: 10/01/17	Committee Approval Obtained: 11/06/20	Section: Administration
<p>*****The most current version of our 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/TX.*****</p> <p>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 STAR+PLUS MMP (Medicare-Medicaid Plan) benefits. 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 both participating and nonparticipating providers and facilities.</p> <p>If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup STAR+PLUS MMP may:</p> <ul style="list-style-type: none"> • Reject or deny the claim. • Recover and/or recoup claim payment. <p>Amerigroup STAR+PLUS MMP reimbursement policies for Amerigroup STAR+PLUS MMP 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 STAR+PLUS MMP strives to minimize these variations.</p> <p>Amerigroup STAR+PLUS MMP 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.</p>		
Policy	<p>Amerigroup STAR+PLUS MMP 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:</p> <ul style="list-style-type: none"> • Documentation must be legible to someone other than the writer. • Documentation must be complete, dated and timed. • Documentation must reflect all aspects of care. 	

<https://providers.amerigroup.com/TX>

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

- 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

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.

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>Other Documentation Not Directly Related to the Member</p> <p>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 STAR+PLUS MMP 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 STAR+PLUS MMP may:</p> <ul style="list-style-type: none"> • Deny the claim. • Recover and/or recoup monies previously paid on the claim. <p>Amerigroup STAR+PLUS MMP is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.</p>
History	<ul style="list-style-type: none"> • Biennial review approved 11/06/20: Minor administrative updates; replaced patient with member • Initial review approved 04/03/17 and effective 10/01/17
References and Research Materials	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • CMS • Texas Health and Human Services Commission (HHSC) • Amerigroup STAR+PLUS MMP contract with HHSC • The Joint Commission
Definitions	<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 by a provider or facility for the same specific medical problem or condition • 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"> • Note