Reimbursement Policy	
Subject: **Documentation Standards for Episodes of Care**	
Policy Number: **G-11004**	Policy Section: **Administration**
Last Approval Date: **12/30/2024**	Effective Date: **12/30/2024**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **provider.healthybluemo.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Healthy Blue covered the service for the member's benefit plan. The determination that a service, procedure, and/or item 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 Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Healthy Blue strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Healthy Blue requires that documentation for all episodes of care meet the following criteria unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise:

Healthy Blue is a Medicaid product offered by Missouri Care, Inc., a MO HealthNet Managed Care health plan contracting with the Missouri Department of Social Services. Healthy Blue is administered statewide by Missouri Care, Inc. and administered in the Kansas City service region by Missouri Care, Inc. in cooperation with Blue Cross and Blue Shield of Kansas City. Missouri Care, Inc. and Blue Cross and Blue Shield of Kansas City are both independent licensees of the Blue Cross Blue Shield Association.
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- Documentation should be legible to someone other than the writer.
- Documentation should be complete, dated, and timed.
- Documentation should reflect all aspects of care.
- Information identifying the member should be included on each page of the medical record.
- Each entry in the medical record should include author identification of the physician or other qualified healthcare provider, which may be a handwritten signature, unique electronic identifier, or initials and rendering provider credentials, as applicable.
- Timely entry of information into a medical record should be completed at the time of service or shortly thereafter and should not exceed 30 days.
- A signature date within 30 days of the date of service should be included with an additional entry of the signature time for services performed in a hospital setting.

To be considered complete, documentation for episodes of care should 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 use 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 needed to consider the medical record complete. Providers should refer to standard data elements that should be included for specific episodes of care as established by The Joint Commission, formerly known as The Joint Commission on Accreditation of Healthcare Organizations.

Other documentation

Documentation not directly related to the member (but relevant to support clinical practice) may be used to support documentation regarding episodes of care, including:

- Policies, procedures, and protocols.

- Critical incident/occupational health and safety reports.
- Statistical and research data.
- Clinical assessments.
- Published reports/data.

Healthy Blue 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, Healthy Blue may:

- Deny the claim.
- Recover and/or recoup monies previously paid on the claim.

Healthy Blue is not liable for interest or penalties when payment is denied or recouped because the provider did not submit required or requested documentation.

Related Coding
Standard correct coding applies

Policy History	
12/30/2024	Review approved and effective: added clarifying language regarding author identification in the medical record, timely entry of information into a medical record, and signature date and time; removed *recorded start and stop times for time-based procedures*
01/01/2021	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services • State contract • State Medicaid • The Joint Commission

Definitions	
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 and Materials
Claims Requiring Additional Documentation
Claims Submission – Required Information for Facilities
Claims Submission – Required Information for Professional Providers

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