Commercial Reimbursement Policy

Subject: **Documentation Standards for Episodes of Care – Professional and Facility**	
Policy Number: **C-20003**	Policy Section: **Administrative**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross (Anthem) member's 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 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, Anthem may:

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

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive 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, Anthem will publish the most current policy to the website.

Policy

The Health Plan requires all documentation for episodes of care be legible to someone other than the writer.

Each record must support the services billed and the level of care provided on each unique date.

For each episode of care, The Health Plan also requires the following:

- Information identifying the member must be included on each page in the medical record.
- Documentation must be complete and dated. Time must be documented, if applicable.

- Each entry in the medical record must include author identification, which may be a handwritten signature, unique electronic identifier, or initials and rendering provider credentials (e.g., MD, RN, etc.), if applicable.
- Timely entry of information into a medical record is expected to be completed at the time of service, or shortly thereafter and should not exceed 30 days.
- Signature date within 30 days of the date of service, and an additional entry of the signature time for services performed in a hospital setting.

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

- Patient 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.
- When testing is performed over several days, all testing time should be reported on the last date of service.

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).

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:

- Policies, procedures, and protocols.
- Critical incident/occupational health and safety reports.

- Statistical and research data.
- Clinical assessments.
- Published reports/data.

The Health Plan 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, we may:

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

The Health Plan is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

Related Coding
Standard correct coding applies

Policy History	
04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: updated policy title to include Facility
01/01/2022	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • AMA Current Procedural Terminology (CPT®) 2020 Professional • CMS • Joint Commission • NCQA (National Committee for Quality Assurance)

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 – Professional and Facility

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.