



Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan members. Please note, this information is specific to the MMC, HARP, CHPlus, and Essential Plan programs only.

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

\*\*\*\* 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 [providerpublic.mybcbswny.com](http://providerpublic.mybcbswny.com). \*\*\*\*

### Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Highmark BCBS 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, Highmark BCBS 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Highmark BCBS 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.

### [providerpublic.mybcbswny.com](http://providerpublic.mybcbswny.com)

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## Policy

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

- 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 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 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:

- Member identifying information
- Consent forms
- Health history including applicable drug allergies
- Physical examinations
- Physician orders
- Immunization records
- Medication prescribed
- Emergency care
- Smoking, alcohol, and substance use history
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports including X-rays
- 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 when applicable
- 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 or data.

Highmark BCBS may request that physicians submit more documentation including medical records or other documentation not directly related to the member to support claims submitted by the physician. If documentation is not provided after the request or notification, or if documentation does not support the services billed for the episode of care, Highmark BCBS may:

- Deny the claim
- Recover or recoup monies previously paid on the claim

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

<b>Related Coding</b>
Standard correct coding applies

<b>Policy History</b>	
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 <i>recorded start and stop times for time-based procedures</i>
11/06/2020	Review approved: minor administrative updates
07/01/2013	Initial approval 07/01/2013 and effective 01/01/2017

<b>References and Research Materials</b>
<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> <li>• CMS</li> <li>• CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services</li> <li>• State contract</li> <li>• State Medicaid</li> <li>• The Joint Commission</li> </ul>

<b>Definitions</b>	
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	

<b>Related Policies and Materials</b>
Claims Requiring Additional Documentation

Claims Submission — Required Information for Facilities
Claims Submission — Required Information for Professional Providers

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