PAYMENT REIMBURSEMENT POLICY

Title: PRP-05 Medical Record Request Standards

Category: PHP_PAYMENT REIMBURSEMENT POLICIES (PRP)

Effective Date: 12/06/2022

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy applies to all network and non-network providers, including but not limited to percent of charge contract providers. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Health Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but which are covered by the Health Plan to support covered benefits available through one of the Health Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms take precedence if there is a conflict between this policy.

2.0 Description:

A patient's medical record is a confidential record of medical care encounters provided to each patient. Providers are responsible for documentation of care provided for every patient encounter. This document includes a record of subjective and objective observations, patient's history, examinations, diagnostic tests, procedures, findings, working and formal diagnosis, outcomes of care, and care plans. Medical record entries must provide a complete and accurate reflection of the procedures/services provided and fully support the coding and claim data submitted for reimbursement. Documentation should reflect the intensity of evaluation and/or treatment, including care plan, complexity of medical decision making, and medical necessity.

The documentation submitted for support is based on the services provided. The Health Plan uses Centers for Medicare and Medicaid Services (CMS) documentation guidelines as best practices to ensure that all relevant medical record components are reviewed as support of services billed. All supporting components of the service must be received within the allotted time frame to avoid denial for lack of supporting documentation. Incomplete records and lack of response to medical records requests may result in denial or reduced reimbursement. This policy serves to assist with Health Plan documentation requirements and medical record request submissions.

3.0 Documentation Requirements:

A. Legibility**:**
   All components of submitted records must be legible. Please be aware that documents with shaded backgrounds or printed on poor quality paper may not copy or fax well. When illegible records are received, the Health Plan or a designated vendor may reach out to the sender to obtain legible copies of the documentation. Services may be considered unsupported by the documentation provided if legible documentation is not received within the allotted time limit, resulting in claim denial.

B. Completeness:

1. Units:

Report units of service accurately. Review HCPCS/CPT® coding descriptions and report units in accordance with the code's defined unit of service. Keywords and phrases located in AMA CPT/HCPC® code descriptions that impact units billed include, but are not limited to, per date of service, each, unilateral, bilateral, up to 1 hour, and each 15 mins.

2. Reports:

a. Operative.

b. Coding should be supported by the details, descriptions, measurements, approach, location, counts, etc., as indicated in the body of the operative report. The body of the operative report must provide a complete narrative of the procedure(s) performed. The information documented under the title or header sections of the operative report or procedure note may not be used to support code selection.

c. Lab/pathology.

d. The report must include Patient Identifiers (name, date of birth); name and address of lab; specimen source when applicable; collection or biopsy date; processing date; test(s) performed; and results. Pathology reports should also include the following detail as applicable: gross description (color, weight, size), microscopic description, type of tumor, grade, tumor size (measured in centimeters), margins, and name of the pathologist.

e. Medical administration (infusions).

f. This report must include name of the drug and National Drug Code (NDC) if unlisted, dosage, route of administration, infusion start and stop times, and wastage when applicable.

3. Time-based services.

a. The time must be separately documented if more than one procedure code is reported for the same date of service, for each specific procedure or time-based service. The record should clearly demonstrate what portion of the total visit was spent performing each of the billed services.

b. Time may be used to bill office or outpatient evaluation and management (E/M) services.

c. Dates of service before 2021:

d. Face-to-face time in the office or other outpatient setting with the patient.

e. Only applicable as a key component for code selection when counseling and/or coordination of care is documented as more than 50% of the visit.

f. Dates of service 2021 and forward:

g. Documentation should indicate the total time spent by physician/qualified health care professionals on the date of service for the following activities:

h. Preparing to see the patient (e.g., review of tests).

i. Obtaining and/or reviewing the separately obtained history.

j. Performing a medically appropriate examination and/or evaluation.

k. Counseling and educating the patient/family/caregiver.

l. Ordering medications, tests, or procedures.

m. Referring and communicating with other health care professionals (when not separately reported).

n. Documenting clinical information in the electronic or other health records only on the date of the visit.

o. Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver.

p. Care coordination (not separately reported).

q. The medical record must include a clear time qualification statement with sufficient information to support the amount of time reported. The statement should be unique to the patient and not a copy and paste statement with general terms. An adequate time qualification statement would include description of the activities performed on the date of the encounter. Total time alone does not support time-based billing.

4. Itemizations:

   Itemizations are required supporting documentation to support services billed under Revenue Code categories for supplies (0270-0279). A complete itemization of service performed must include a patient identifier(s), date of service, Revenue Codes, clear description of each service/item, quantity, and charges for each corresponding service/item. Descriptions that state "supply" but do not accurately identify the supply item billed may result in denials.

5. Invoices:

   Invoices are not the same as itemizations. Invoices are specific to the cost of a billable item such as a drug, supplies, or implantable device. These may be requested for pricing or in support of charges identified as excessive charges. An invoice should identify the supplier, the purchaser, the patient the services are being billed for, date of invoice, item description, units billed, cost per line item, total cost, and discounts if applicable.

6. Patient Identifiers:

   Each page of the patient's medical record should contain the patient's legal name, the licensed health care provider's name, and the date of service.

   Proof of delivery/receipt:

   The Health Plan follows CMS proof of delivery documentation guidelines for verification of coding and receipt of billed items. Proof of delivery may be requested for any supply items not considered a professional service. This includes but is not limited to DME, oral appliances, orthotics, and prosthetics. A complete proof of delivery must identify the supplier, date of delivery, name of recipient/patient, detailed description that identifies the item(s) delivered, and signature. The date of service on the claim must match the date on the signed proof of delivery. Recognized delivery methods include delivery to the member/patient or authorized representative directly (pick-up), shipping or delivery service, or delivery to the home/nursing

facility. Proof of delivery for items delivered using a shipping or delivery service using a tracking number must include an invoice with item details and corresponding tracking number.

7. Signature:

   Signature requirements may vary based on services. The Health Plan signature requirements align with CMS guidelines unless otherwise indicated in a Health Plan Payment and Reimbursement Policy, Medicare Benefit Policy Manual, Chapter 15, Section 80.6.1, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4, and MLN Matters® Article SE1419. The Health Plan follows CMS signature guidelines. Electronic signatures are acceptable when identified as such in an electronic health record. A signature log or attestation may be requested to identify the signer if a signature is not legible. Medical records submitted for review with missing or incomplete signatures may result in claim denials.

8. Quantities/measurements:

   Some services are coded based on specific details such as quantities and measurements. These details must be specifically documented in the body of the operative report. If quantities are not specified, only one unit is supported. Generic terms such as "several," "multiple," or "a couple" are not sufficient. If measurements are not documented clearly to support code selection, this may result in supporting the lowest of a code range or denial. For example, documentation repair (closure) codes must include specific measurements in the body of the operative report, such as 2X3cm.

9. Orders/requisitions:

   An order to be performed is required for many diagnostic and therapeutic services. These services include but are not limited to labs, x-rays, scans, EKGs, DME, and prescriptions. Orders must be from a licensed provider that has evaluated the patient. Complete order must be available for review if requested and include the date or prior to the date of service but within 365 days of service, description of service/item, and signature.*

   * There are some instances where a signature may not be required, such as clinical diagnostic lab tests. Medical documentation such as a practitioner-signed progress note indicating a clinical diagnostic test to be performed to support intent will suffice.

10. Cloned/copy and pasted medical records:

    Use caution when entering information into electronic medical records. Repeated and outdated notes lead to an unreliable and inaccurate record of events and services. Medical records may be considered Cloned documentation when multiple entries in a patient chart are identical or similar to other entries in the same chart or other patient charts without the expected variations in diagnosis and treatment. If documentation is determined to be copied or Cloned, it shall be considered inadmissible as support for service.

C. Documentation Amendments.

All services should be documented in the medical record at the time the services are rendered. On rare occasions, certain entries related to services provided are not entered at the time of service. The Health Plan considers submitted entries that comply with the following record-keeping principles.

1. Record-keeping principles.

   Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to the Health Plan containing Amendments, corrections, or addenda must:

a. Clearly and permanently identify any Amendment, correction, or delayed entry.

b. Clearly indicate the date and author of any Amendment, correction, or delayed entry.

c. Clearly identify all original content without deletion.

d. Be completed in a timely manner.

2. Paper medical records: When correcting a paper medical record, these principles are generally accomplished by:

a. Using a single line strike-through, so the original content is still readable.

b. The author of the alteration must sign and date the revision. Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name.

c. The Health Plan does not consider any entries that do not comply with the principles listed above, even if such exclusion would lead to claim denial.

i. For example, undated or unsigned entries handwritten in the margin of a document are not considered.

ii. An Amendment should not be used to prove the medical necessity or the fact that a service was performed; instead, use it to support the original information.

D. Documentation requests and submissions:

1. The Health Plan may request medical record documentation for review on a prepayment or post-payment basis. In accordance with the Department of Insurance and Financial Services a Clean Claim means a claim that does all the following:

a. Identifies the health professional, health facility, home health care provider, or durable medical equipment provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.

b. Sufficiently identifies the patient and Health Plan subscriber.

c. Lists the date and place of service.

d. Is a claim for covered services for an eligible individual.

e. If necessary, substantiates the medical necessity and appropriateness of the service provided.

f. If prior authorization/approval (PA) is required for certain patient services, contains information sufficient to establish that PA was obtained.

g. Identifies the service rendered using a generally accepted system of procedure or service coding.

h. Includes additional documentation based upon services rendered as reasonably required by the Health Plan.

2. If the Health Plan determines that a claim is not clean due to the claim requiring supporting documentation, which can include medical records, and/or itemized statements, the claim or claim lines are denied with an explanation code indicating the information needed to be considered for payment on the provider explanation of payment (EOP). Providers have six months or as otherwise specified in the provider participation agreement after receiving the EOP to submit the requested documentation.

3. In order for the claim to be reconsidered, the provider must:

    a. Return the requested supporting documentation to the Health Plan or to the address indicated on the Health Plan's EOP.

    b. Ensure that the Health Plan receives the requested supporting documentation within six months from the date on the Health Plan's EOP or as otherwise specified in the provider participation agreement.

    c. Not bill a member for services for which a claim submission has been returned to the provider for supporting documentation.

4. If the requested supporting documentation is not submitted as requested within the allotted timeline, a claim may not meet the required definition of a Clean Claim and be considered unsupported. Unsupported claims may result in claim denials or reduced allowable.

E. Timelines.

1. Change Healthcare documentation requests.

    a. The Health Plan partners with Change Healthcare for assistance with documentation requests for audit reviews.

    b. Documentation requests from Change Healthcare on behalf of the Health Plan must be responded to within 30 days to prevent claim denials and any delay in reimbursement.

    c. It is recommended that all requested documentation is gathered and submitted together. Documentation can be faxed to 949.234.7603 or to medicalrecords@changehealthcare.com.

2. Denials for incomplete/lack of documentation.

    a. Do not submit a new claim. Submission of additional claims may result in duplicate denials and delay of reimbursement.

    b. Review explanation of denial code on your EOP to determine where the documentation should be submitted.

    c. If a claim or portion of a claim is denied due to lack of or incomplete documentation, please refer to your contract for timely filing limitations to meet Clean Claim requirements.

3. Appeals.

    a. Providers have 90 calendar days from the date of the initial claim denial to file an appeal with the Health Plan.

    b. If documentation is submitted after timely filing and/or appeal time limits, the denial stands, and no further review shall occur.

F. Confidentiality.

All members' medical records must be maintained in a secure, locked area that is not accessible to the general public. This applies to paper and electronic records. The office should have a written policy and an established process to maintain record confidentiality at all times. Additional security measures should be established to protect medical records consistent with the Administration Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or any similar federal or state statutes and regulations. The Health Plan has policies and procedures in place to preserve the confidentiality of all members' protected health information and records in accordance with any applicable statutes and regulations. The Health Plan adheres to such policies and procedures at all times.

4.0 Verification of Compliance:

Claims are subject to audit, prepayment, and post-payment to validate compliance with the terms and conditions of this policy.

5.0 Terms & Definitions:

Amendment: A minor change or addition designed to improve a text, piece of documentation, etc.

Clean Claim: A claim without defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment.

Cloning: The copying and pasting of patient information in an Electronic Medical Record (EMR) from one service date to another for the same patient.

Legibility: the quality of being clear enough to read.

Patient Identifiers: Any alphanumeric code used to uniquely identify a patient within a health register or health records system.

Protected Health Information (PHI): Any personally identifiable demographic information that can be used to identify a patient. HIPAA sets national standards for the privacy and security of PHI.

Revenue Codes: A numeric code, which identifies a specific accommodation, ancillary service or billing calculation, as defined by the National Uniform Billing committee for UB-92 forms.

6.0 References, Citations & Resources:

PRP-03 Unlisted CPT/HCPCS Codes

PRP-11 Drugs & Biologicals

7.0 Revision History:

Original Effective Date: 01/01/2020

Next Revision Date: 12/06/2023

Revision Date	Reason for Revision
10/21	Annual Review approved CCS 10-19
12/22	Annual Review