Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Program Integrity Amendments, Corrections, and Delayed Entries

Policy Number: RM006
Last Review: 02/01/2024

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
X Facility

DESCRIPTION:

All services provided to Members are expected to be documented in the medical record at the time the services are rendered. Occasionally, changes/updates to the medical record entry are needed. In this event, documentation to determine proper payment for services, may be amended (corrected or entered) after rendering the service.

An addendum is used to add information to a record which was not available at the time of the original entry. Addendums should be added timely as the provider must be able to recall the details of the patient encounter. Addendums should be an exception rather than a routine for the practice.

Paramount reserves the right to request supporting documentation. The documentation will be used to validate services billed for Member services rendered or ordered.

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Paramount expects documentation will be generated at the time a service is rendered or as soon as practicable after it is provided to maintain an accurate medical record. When amendments, corrections, or delayed entries, must be made it is expected the documentation will be legibly corrected in a manner which allows the reviewer to identify what is being corrected and why.

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted containing amendments, corrections or addenda must:

- Clearly and permanently identify any amendment, correction, or delayed entry as such, and
- Clearly indicate details of the amended information, and
- Clearly indicate the date and author of the amendment, correction, or delay entry, and
- Clearly identify all original content, without deletions.

Paper Medical Records:

When correcting a paper medical record, these principles are accomplished by:

- Using a single line strike through so the original content is still readable (never erase or delete the original entry), and
- Document the correction, include a reason for the correction above or in the margin or within the correction, and
- Document the correct revision information with the current date and the provider's signature* or initials**.

*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.

Electronic Health Records (EHR):

Medical record keeping within an EHR deserves special considerations; however, the principles specified above remain fundamental and necessary for document submission. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

- Distinctly identify any amendment, correction or delays entry, and
- Provide reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

All entries in the medical record must be legible to another reader, including but not limited to, the identity of the provider of the services.

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 10/01/2019

Date	Explanation & Changes
10/01/2019	• Reimbursement Policy created
11/01/2023	• Reimbursement Policy reviewed and updated to reflect the most current reimbursement/billing criteria

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

Industry Standard Review