Enhanced Primary Care
The CDPHP® Medical Home

Section 21
Enhanced Primary Care

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Frequently Asked Questions

What is PCMH?

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care and creating a health care environment that facilitates partnerships among individual patients, their personal physicians, and when appropriate, the patient's family. The PCMH aims to achieve improvements in the quality and efficiency of health care though the transformation of how primary care is practiced.

What is EPC?

Enhanced Primary Care (EPC) is the proprietary name for the CDPHP PCMH. The concept behind EPC is that the combined savings associated with better health outcomes and lower utilization will be sufficient to fund enhanced compensation to primary care physicians. Practice sites are reimbursed via a severity-adjusted base compensation payment methodology with an opportunity to earn bonuses for the provision of quality care.

How do I learn more about CDPHP's EPC program?

Visit the EPC web page at https://www.cdphp.com/providers/programs/enhanced-primary-care.

Do all practitioners in a practice need to participate in order for the practice to be considered an EPC site?

Yes, all practitioners in a practice need to participate.

How do I submit claims for the EPC program?

The process for EPC providers to submit claims is the same as it would be for any other practice. The only additional required data element on all EPC claims is the National Provider Identifier (NPI) for the provider site.

How do I get a site NPI?

To obtain a site NPI, contact the CMS Site NPI Enumerator online at nppes.cms.hhs.gov, or by calling 1-800-465-3203; or by mail at:

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

What version of the HIPAA electronic transaction must be used for claim submission?

All physicians and clearinghouses that submit HIPAA transactions are required to use ASC X12 version 5010 as of January 1, 2012.

What is a PAL?

"PAL" or "Patient Acuity Level": the severity score determined by Capital District Physicians' Health Plan, Inc., in its discretion, for each Imputed Member using a proprietary tool designed to predict key differences in resource utilization across patients.

How frequently is PAL updated?

The PAL scores are updated monthly.

Can the PAL be retroactively adjusted?

No. The PAL relies on accurate coding and timely submission of all medical claims. No retroactive adjustments will be made to the PAL score.

How long do I have to submit claims?

EPC participation does not change the length of time allowed to submit claims to CDPHP. Keep in mind that member imputation is based on member encounters. Timely claim submission will help us keep your patients imputed to the correct providers, resulting in appropriate payment for your practice. Please refer to your CDPHP participating provider agreement for full information.

How many diagnosis codes can be submitted on a claim?

The CDPHP claim payment system can accommodate up to 12 diagnosis codes on a claim. We urge your practice to confirm with your EMR vendor the number of diagnoses you are sending to CDPHP.

How would I submit claim appeals?

There is nothing different about the claim appeals process for the EPC. Please refer to Section 10 of the *CDPHP Provider Office Administrative Manual (POAM)*.

Are all CDPHP products eligible for the compensation payment model?

No. Members of groups covered by a Capital District Physicians' Healthcare Network, Inc. (CDPHN) self-insured plan (select ASO groups) and members in a Medicare Supplemental plan currently are not eligible to have their providers reimbursed under the EPC compensation model. Claims for these members will be paid under the fee-for-service model until further notice.

How do members impute to a practice site?

The imputation logic looks at services rendered within the previous 18 months to eligible members. A member is imputed to a particular practitioner based on the evaluation and management (E&M) services provided.

How do I get specific details on a member's imputation?

A member who has had eligible claim activity and meets imputation logic criteria will be imputed to a practitioner at the beginning of each month. If you have questions on a member who is active with your practice, meets imputation criteria, and currently has active coverage with CDPHP, please review your EPC reports on the secure portal for information on imputation and payments.

When do I get paid for a member under the compensation model?

The compensation payment will be sent to all EPC practices once a month. Compensation is run on the first Sunday of every month and payments are mailed by our payment vendor on the following Tuesday. In the event of a Monday holiday, checks are mailed on Wednesday. As a result, compensation checks can be mailed anywhere from the third to the tenth of the month.

When do I get paid for a member who is not under the compensation model?

There is no change to the payment schedule for claims that are paid on a fee-for-service basis. This check will be separate from the compensation reimbursement and continue to come on a weekly basis.

Electronic Funds Transfer

- CDPHP offers Electronic Funds Transfer (EFT) of payments to our providers.
- You may select EFT payments regardless of whether your remittance type is 835 or paper.
- Please visit CAQH at https://solutions.caqh.org/bpas to obtain additional information and sign up for EFT services.

Contact Information for EFT Assistance:

- Phone: (844) 815-9763
- Email: EFThelp@enrollhub.CAQH.org

How do I know which codes pay via compensation versus fee-for-service?

CDPHP has established a list of codes that will be carved out of the fee-for-service reimbursement arrangement and will be included in the EPC payment methodology. The list can be found in your CDPHP Enhanced Primary Care payment policy.

In reference to the HIPAA 835 remittance advice: How do I know which claims are paid under the EPC compensation model?

In the 835 transaction you will see a claims adjustment group code of CO and a claim adjustment reason code of 24. (The list can be found in the Payment Policy EPC Service Codes under policies on cdphp.com.)

How are coordination of benefits claims processed?

When CDPHP coverage is secondary to another commercial or Medicare medical plan, then the secondary plan is excluded from the EPC payment model. Any claims payment would be based on coordination of benefits. Please see Section 8 of the *POAM* for additional details.

Do I still collect or bill for patient responsibility?

Yes. All member liabilities should be billed in the normal fashion.

Do I need to see my patient before I refer him/her to a specialist?

There is no change in the referral process for an EPC practitioner. However, partnering with your patients in their care is an integral part of the EPC model. An EPC practitioner would need to be aware of their patients' need for specialist care, and if necessary, assist the patient in obtaining the services.

Enhanced Primary Care Program Definitions

The following table lists various terms related to the EPC program, along with their definitions.

Term	Definition
EPC Service Code List	List of covered procedure codes (Enhanced Primary Care [EPC] Service Codes & Quality Enhanced Service Codes), solely reviewed and determined by CDPHP, which detail the services performed in an office that will be reimbursed under the base compensation arrangement.
Base Compensation Arrangement	A monthly payment sent to the practice site based on covered services provided to imputed EPC members.
Imputation Override	A determination made by the medical director to include or exclude a member from the base compensation payment model.
EPC	Enhanced Primary Care
FFS Equivalent	Where EPC base compensation is applied, the amounts CDPHP would have paid or allocated using FFS fee schedule.
Imputation	The process of deriving the relationship between a member and a provider.
Member Detail Report	This report lists out the current monthly member roster for the provider site broken down by provider; it also list those members who have been removed from the site's base compensation and those that have been added to the site's base compensation.
Member Liability Deduction	Any cost share incurred by the member according to product rules, including coinsurance, copay, and deductible. These monies will be deducted from the base compensation payment on a monthly basis for any claims paid in the previous month in which member responsibility was collected.
Payment Roster	The current monthly roster along with payments made and the calculation information for those payments. Also includes member liability deduction information.
PAL (Patient Acuity Level)	The severity score determined by CDPHP, in its discretion, for each imputed member using a proprietary tool designed to predict key differences in resource utilization across patients.
Severity Adjusted Case Management Fee	An additional PMPM (per member per month) fee for the physician's members <18 years of age.
Site	Unique physical location of provider practice. For the purposes of EPC, must have its own unique NPI. A provider group may have multiple sites.
Site Level NPI	National Provider Identification (NPI) is a unique practice site identifier issued by the Centers for Medicare & Medicaid Services. For corporate groups, this is the number assigned to each individual practice site contained in the corporation.

Enhanced Primary Care Site NPI

EPC participation is predicated upon the transformation of practitioner office sites and the association of the members receiving care from physicians at those sites. To ensure accurate reporting and practitioner reimbursement, CDPHP must systematically identify the EPC office site in its claim adjudication process.

CDPHP is requiring that all corporate entities that are participating in EPC obtain "Site" NPI numbers for each EPC and non-EPC physical office site within their company and that the Site NPI be placed on all submitted claims in the site of services NPI field – Box 32 on paper claims and Loop 2310D (4010 version) or Loop 2310C (5010 version) on the 837P file.

To obtain a Site NPI, contact the NPI Enumerator via:

Website: https://nppes.cms.hhs.gov/NPPES/welcome.do
Phone: 1-800-465-3203
Mail: NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

When completing the NPI application please ensure that you complete section 3 with your:

A. Mailing Address
B. Business Practice Location. This should be your physical office site location
D1. Taxonomy: 193400000X (Single Specialty) or 261QM1300X (Multiple Specialty)
D2. License: This should be the principal physician's license number and state for the physical site. This should be unique between sites to prevent a duplication error.

When you have obtained all your NPI numbers, fax or email the attached completed EPC Provider Structure Data Sheet with printouts of the NPPES NPI data page(s) and roster of practitioners by physical location to:

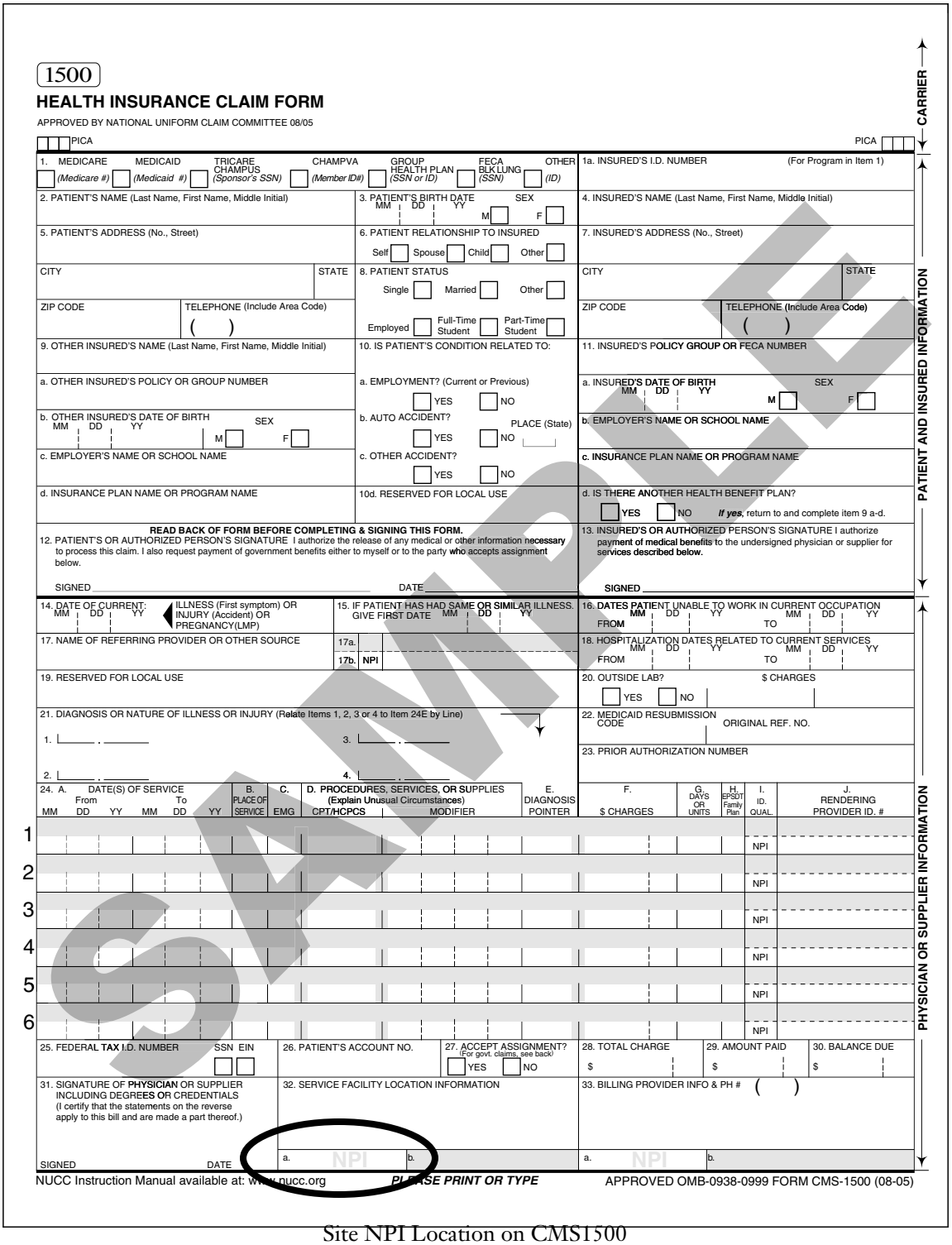
Provider Registry
CDPHP
6 Wellness Way
Latham, NY 12110
Fax: (518) 641-3209
provider_registry@cdphp.com

Frequently Asked Questions

Q. Where do I put the Site NPI on paper claims?
A. Box 32a

Q. Where do I put the Site NPI on 837P claims?
A. Loop 2310D (4010 version) or Loop 2310C (5010 version)

Q. Do I still put my group NPI on the claim?
A. Yes. Box 33a for paper and Loop 2010AA for 837P.



Site NPI Location on CMS1500

EPC Provider Structure Data Sheet

Group Practice/Corporate Name: _____

Tax #: _____ Existing Billing NPI#: _____

Claim Remit Address: _____

_____

Claim Remit Roll Up Method:

☐ Roll up all claim activity to the corporate level combining multiple physical sites activity into consolidated check(s), voucher(s), and/or 835 files. The organizational NPI# listed within the 835 would be the Financial NPI#.

☐ Separate all claim activity to the physical site level reporting each physical site claim activity on separate check(s), voucher(s), and/or 835 files. The organizational NPI# listed within the 835 would be the Site NPI#.

Site NPI Information:

For each site NPI, please attach copies of the National Plan and Provider Enumeration System (NPPES) web page and a list of the associated practitioners working from that physical site.

Name and Title (print): _____

Signature: _____ Date: _____

Base Compensation Payment Schedule

Base compensation is run at the beginning of every month and payments will be mailed by our vendor by the 15th of the month.

Retroactive Claim Adjustment

There may be instances where a retroactive adjustment could occur on encounters that have been paid under the base compensation arrangement.

- Imputation changes—Imputation is retroactively updated based on claims data. Claims will be reexamined and adjusted accordingly if an imputation change affects the original payment of a claim.
- Eligibility—Any base compensation payments made on a member who is no longer effective will be adjusted accordingly. This could occur due to retroactive terminations requested by an employer group or a governmental agency (i.e., Medicaid) or due to the death of a member.

Enhanced Primary Care Imputation Methodology

The process of deriving the relationship between a member and a provider is described below:

Imputation Data:

Utilization data is the foundation for establishing the relationship. Services included in the analysis must meet the following criteria:

1. The member must be eligible for the imputation month. A member is considered eligible for the entire month if he/she has active coverage on the 15th.
2. The service(s) must be rendered within the past twelve (12) months of the imputation date.
3. If no service is rendered within the past 12 months, imputation based on the previous 12 months is carried forward for up to another 6 months (18 month look-back).
4. The claim on which the service(s) were submitted must be in a finalized state. A claim is considered final once it has been paid or denied.
5. The service(s) must be rendered by a participating primary care physician or physician extender.
6. The type of service is deemed as evaluation and management (E&M) and rendered in an office setting defined by place of service:
   - 02 – Telehealth Provided Other than in Patient's Home
   - 10 – Telehealth Provided in Patient's Home
   - 11 – Office
   - 19 – Off Campus Outpatient Hospital
   - 22 – On Campus Outpatient Hospital
   - 49 – Independent Clinic
   - 50 – Federally Qualified Health Center
   - 71 – State or Local Public Health Clinic
   - 72 – Rural Health Clinic

Imputation Algorithm:

Once the data is gathered, the imputation decision is based on a hierarchy of rules. Imputation occurs at two (2) levels: the individual provider, and the provider site. The first rule that can be met by a single entity will determine the relationship. The rules are cumulative, meaning the entities must meet the previous rule in order to be considered in the next.

The member will be assigned to the provider entity who:

1. Rendered the most E&M services; or
2. Rendered the most preventive services; or
3. Was the imputed entity for the previous month; or
4. Had the highest total allowed dollars; or
5. Performed the most recent service.

At least one E&M service performed	Only one PCP performed Most E&M services	Only one PCP performed most preventative services	Only one remaining PCP is the prior month's imputed PCP	Only one remaining PCP has highest total allowed amount	Only one remaining PCP performed most recent DOS	Imputed PCP?	Which PCP
Y						Y	Single
	Y					Y	Most E&M services
		Y				Y	Most Preventative services
			Y			Y	Prior month's imputed
				Y		Y	Highest total allowed amount
					Y	Y	Most Recent office based DOS

Imputation Default (18-month look-back):

There are situations where the above algorithm will not produce a relationship. This will happen when either there is no utilization data that meets the selection criteria, or when multiple provider entities meet all of the algorithm rules. When this occurs, the imputed entity's relationship will be extended into the current month for a maximum of six (6) months.

Imputation Effective Dates:

Imputation will occur monthly. The execution of the process will occur after the last payment process for the month and the relationship will be prospectively dated for the first of the following month and will be active for the entire month. There will not be any partial month imputations.

Imputation Recasting:

The imputation process will retrospectively calculate the relationships previously established for a period of 12 months in order to accommodate claim submission and processing lag time. If the

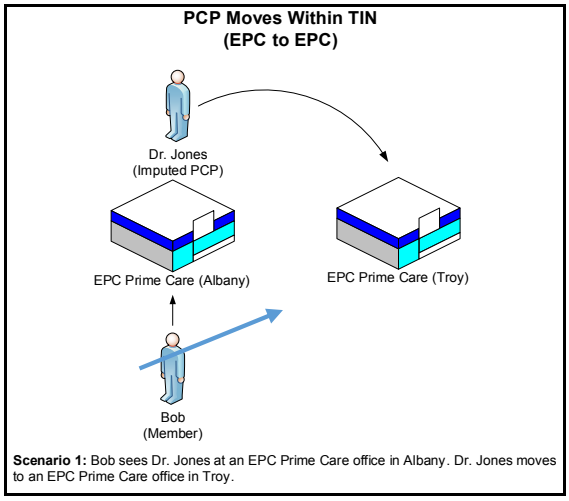
imputed relationship has changed at the provider site level, base compensation payment adjustments will be necessary.

Imputation Exclusions and Overrides:

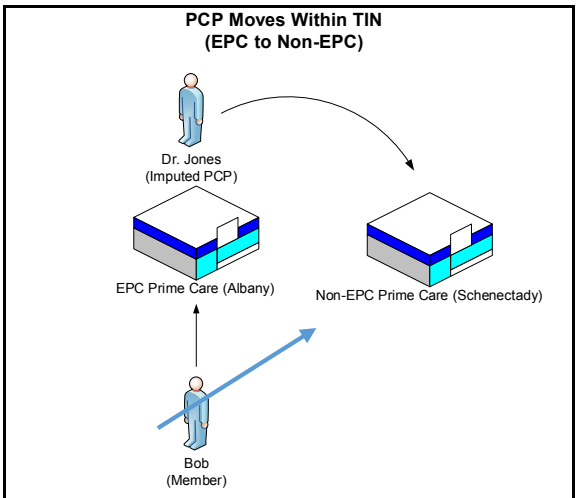
There are cases when the imputed provider entity will not be included in the Enhanced Primary Care (EPC) payment methodology for a particular member. This will happen when the member's insurance coverage is secondary to another plan.

Member Imputation Scenarios by Action

1. **Individual Physician moves from one Site to another within the existing TIN**
   In the following scenarios, the imputed Member will remain imputed to the Physician, including Carry Forward Members.

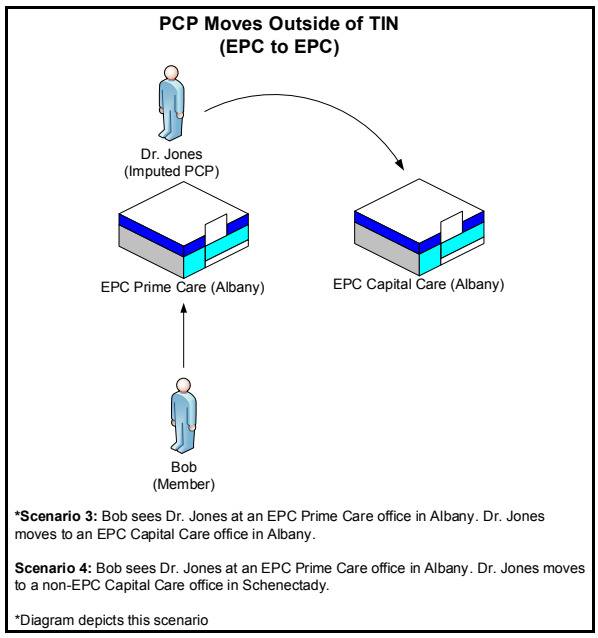


Scenario 1: Bob sees Dr. Jones at an EPC Prime Care office in Albany. Dr. Jones moves to an EPC Prime Care office in Troy.



Scenario 2: Bob sees Dr. Jones at an EPC Prime Care office in Albany. Dr. Jones moves to a Non-EPC Prime Care office in Schenectady.

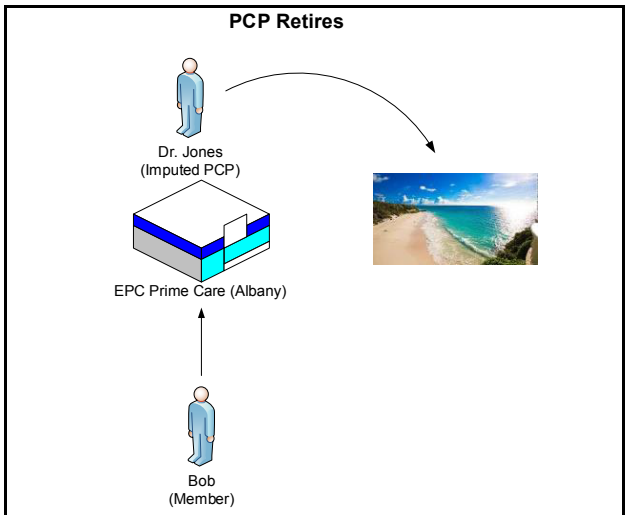
2. **Individual Physician moves from one Site to another outside of their current TIN, or is no longer active with CDPHP.**
   In the following scenarios, the existing imputed Members will be removed, including Carry Forward Members, and any Member utilization prior to the Physician's termination from the TIN will not be considered for future imputation.



***Scenario 3:** Bob sees Dr. Jones at an EPC Prime Care office in Albany. Dr. Jones moves to an EPC Capital Care office in Albany.

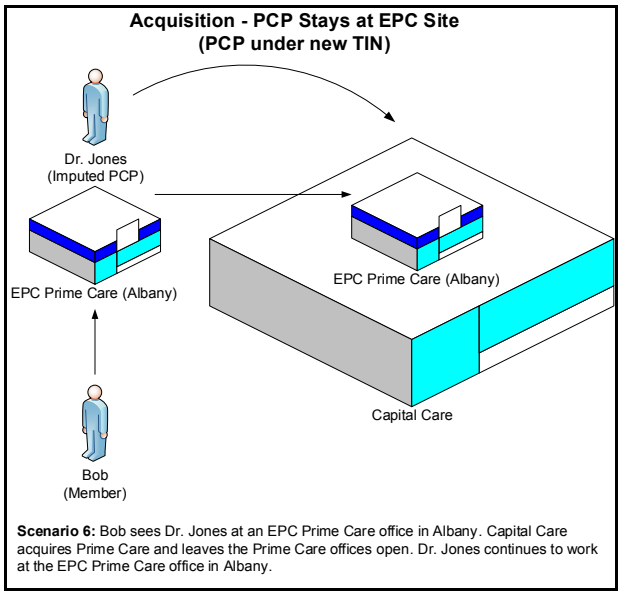
Scenario 4: Bob sees Dr. Jones at an EPC Prime Care office in Albany. Dr. Jones moves to a non-EPC Capital Care office in Schenectady.

*Diagram depicts this scenario

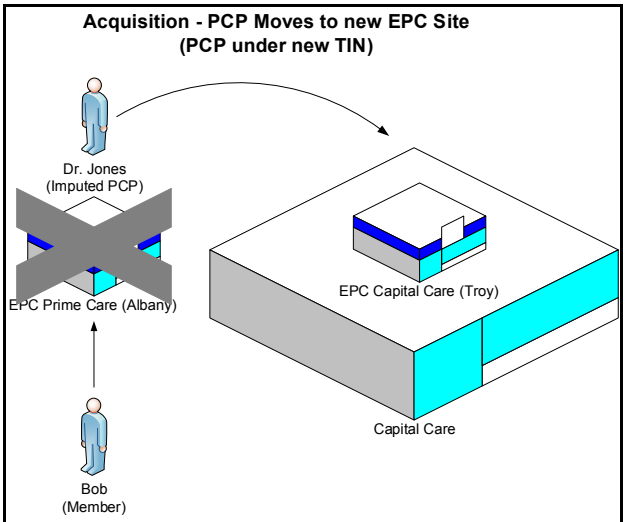


Scenario 5: Bob sees Dr. Jones at an EPC Prime Care office in Albany. Dr. Jones retires.

3. **An entire TIN is acquired by another TIN, or a single Site under a TIN is acquired by another TIN**
   In the following scenarios there are two possible results:
   a. The existing imputed Members will be removed, including Carry Forward Members, and any Member utilization prior to the Physician's termination from the TIN will not be considered for future imputation. (Note: This will be the default if the appropriate request has not been submitted in order to accomplish option 3b.) (Single Site acquisitions only)
   b. The imputed Members will remain imputed to the Physician by means of linking the Physician's new TIN to the original TIN, and considering all of the Member's prior utilization under the Physician. (Note: This will need to be accomplished by means of a specific request to link the Physician's new and original TINs for single Site acquisitions)



Scenario 6: Bob sees Dr. Jones at an EPC Prime Care office in Albany. Capital Care acquires Prime Care and leaves the Prime Care offices open. Dr. Jones continues to work at the EPC Prime Care office in Albany.

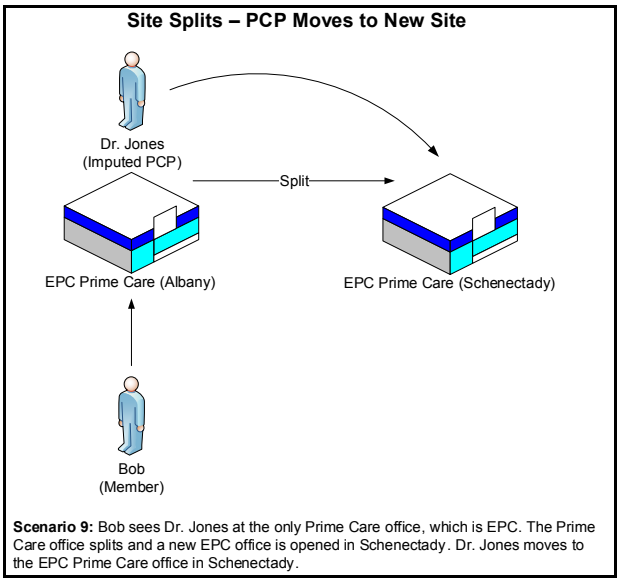


***Scenario 7:** Bob sees Dr. Jones at an EPC Prime Care office in Albany. Capital Care acquires Prime Care and closes the Prime Care offices. Dr. Jones moves to the EPC Capital Care office in Troy.

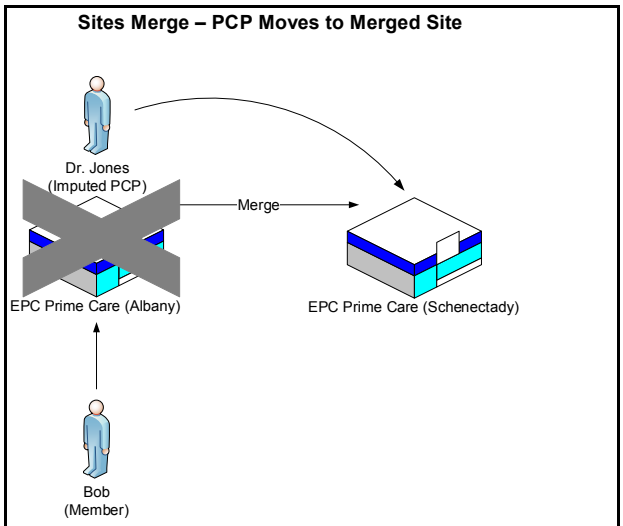
Scenario 8: Bob sees Dr. Jones at an EPC Prime Care office in Albany. Capital Care acquires Prime Care and closes the Prime Care offices. Dr. Jones moves to the Non-EPC Capital Care office in Schenectady.

*Diagram depicts this scenario

4. **A Site splits or two Sites merge, either within one existing TIN or between two TINs**
   In the following scenarios there are three possible results:
   a. In cases where the TIN remains the same, the imputed Member will remain imputed to the Physician.
   b. In cases where there is a change in TINs one of the following is possible:
      i. The existing imputed Members will be removed, including carry forward Members, and any Member utilization prior to the Physician's termination from the TIN will not be considered for future imputation. (Note: This will be the default if the appropriate request has not been submitted in order to accomplish option 4bii.)
      ii. The imputed Members will remain imputed to the Physician by means of linking the Physician's new TIN to the original TIN, and considering all of the Member's prior utilization under the Physician. (Note: This will need to be accomplished by means of a specific request to link the Physician's new and original TINs.)



Scenario 9: Bob sees Dr. Jones at the only Prime Care office, which is EPC. The Prime Care office splits and a new EPC office is opened in Schenectady. Dr. Jones moves to the EPC Prime Care office in Schenectady.



Scenario 10: Bob sees Dr. Jones at an EPC Prime Care office in Albany. This office merges with an EPC Prime Care office in Schenectady, and closes the Albany office. Dr. Jones moves to the EPC Prime Care office in Schenectady.

Example of an EPC Payment Voucher

CAPITAL DISTRICT PHYSICIANS'
HEALTHCARE NETWORK, INC. (CDPHN)

Albany County

Check Date: 11/01/2020
Provider ID:
TIN:
NPI:
Check No: 123456789
Amount: $1,321.53

FOR TELEPHONE INQUIRIES CALL:
(518)641-3500
1-800-926-7526

Temp-Return Service Requested

000014-000002-000016-000179 2663655 1540CDK F
Jane Doe, MD
PO Box 1234
Albany, NY 12205

EPC Payment

Capitation Payment 18 and Over

Month	Member #	Member Name	Product	PAL	Payment Amount *
11/20	CD		ASO Non-HMO	15.7420	$44.26
11/20	CD		ASO Non-HMO	1.1250	$34.37
11/20	CD		ASO Non-HMO	0.4620	$28.83
11/20	CD		ASO Non-HMO	0.7830	$31.76
11/20	CD		ASO Non-HMO	1.6050	$38.06
11/20	CD		ASO Non-HMO	0.6510	$30.80
11/20	CD		ASO Non-HMO	0.6840	$30.80
11/20	CD		ASO Non-HMO	0.6510	$30.80
11/20	CD		ASO Non-HMO	0.2400	$25.58
11/20	CD		ASO Non-HMO	3.5040	$44.26
11/20	CD		ASO Non-HMO	0.7280	$30.80
11/20	CD		ASO Non-HMO	3.3200	$44.17
11/20	CD		ASO Non-HMO	0.6510	$30.80
11/20	CD		ASO Non-HMO	0.4070	$27.78
11/20	CD		ASO Non-HMO	3.4770	$44.26
11/20	CD		ASO Non-HMO	0.3960	$27.78
11/20	CD		ASO Non-HMO	4.0740	$44.26
11/20	CD		ASO Non-HMO	0.7640	$31.76
11/20	CD		ASO Non-HMO	0.4620	$28.83
11/20	CD		ASO Non-HMO	0.3720	$27.78
11/20	CD		ASO Non-HMO	1.3530	$36.69
11/20	CD		ASO Non-HMO	0.7830	$31.76
11/20	CD		ASO Non-HMO	1.5920	$38.06
11/20	CD		ASO Non-HMO	1.2210	$35.16
10/20	CD		ASO Non-HMO	0.6840	$30.80
11/20	CD		ASO Non-HMO	0.6840	$30.80
11/20	CD		ASO Non-HMO	0.7280	$30.80
11/20	CD		ASO Non-HMO	0.7830	$31.76
10/20	CD		ASO Non-HMO	0.7830	$31.76
11/20	CD		ASO Non-HMO	0.7830	$31.76
11/20	CD		ASO Non-HMO	1.3530	$36.69
11/20	CD		ASO Non-HMO	0.5830	$29.82

ADMINISTERED BY CDPHN
Capital District Physicians' Healthcare Network

JPMORGAN CHASE BANK, N.A.
Rochester, NY

No.

DATE
11/01/2020

AMOUNT
$1,321.53

One Thousand Three Hundred Twenty-One and 53/100 Dollars

PAY
TO
THE
ORDER
OF

Jane Doe, MD
PO Box 1234
Albany, NY 12205

CDK

CAPITAL DISTRICT PHYSICIANS'
HEALTHCARE NETWORK, INC. (CDPHN)

Check Date: 11/01/2020
Provider ID:
TIN:
NPI:
Check No: 123456789
Amount: $1,321.53

FOR TELEPHONE INQUIRIES CALL:
(518)641-3500
1-800-926-7526

Month	Member #	Member Name	Product	PAL	Payment Amount *
11/20	CD		ASO Non-HMO	0.7560	$31.76
Total					**$1,105.36**

*** Please refer to your contract for full details on payment calculations.**

Capitation Payment Under 18

Month	Member #	Member Name	Product	Base Rate	Care Mgmnt Fee*	Total (Base Rate + Care Management Fee)
11/20	CD		ASO Non-HMO	$26.94	$2.50	$29.44
11/20	CD		ASO Non-HMO	$23.25	$2.50	$25.75
11/20	CD		ASO Non-HMO	$37.21	$1.00	$38.21
11/20	CD		ASO Non-HMO	$74.03	$5.00	$79.03
11/20	CD		ASO Non-HMO	$74.03	$5.00	$79.03
11/20	CD		ASO Non-HMO	$37.21	$2.50	$39.71
Total						**$291.17**

*** For Imputed EPC Member with Patient Acuity Level of 0 to ≤ .1, a fee of $1.00 PMPM;**
*** For Imputed EPC Member with Patient Acuity Level of >.1 to ≤ .2, a fee of $2.50 PMPM;**
*** For Imputed EPC Member with Patient Acuity Level of >.2 to ≤ 1.0, a fee of $5.00 PMPM; and**
*** For Imputed EPC Member with Patient Acuity Level of > 1.0, a fee of $10.00 PMPM.**

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CAPITAL DISTRICT PHYSICIANS'
HEALTHCARE NETWORK, INC. (CDPHN)

Check Date: 11/01/2020
Provider ID:
TIN:
NPI:
Check No: 123456789
Amount: $1,321.53

FOR TELEPHONE INQUIRIES CALL:
(518)641-3500
1-800-926-7526

Member Liability Deductions

Servicing Provider: Jane Doe, MD
Servicing Provider Group Site:

Servicing Provider:
Servicing Provider Group Site:

Claim#-Seq	Claim DOS	Member #	Product	Member Name	Pt Acct #	Copay	Co-Insurance	Deductible	Total
-00001	09/25/20	CD	ASO Non-HMO			-$25.00	$0.00	$0.00	-$25.00
-00001	09/18/20	CD	ASO Non-HMO			-$25.00	$0.00	$0.00	-$25.00
-00001	10/08/20	CD	ASO Non-HMO			-$25.00	$0.00	$0.00	-$25.00
Sub Total						-$75.00	$0.00	$0.00	-$75.00
Member Liability Deductions Total						**-$75.00**	**$0.00**	**$0.00**	**-$75.00**

Member liability for services rendered by your practice is subtracted from your monthly capitation payment.
Please note - Member billing should not be generated from this document.

Payment Amount **$1,321.53**

Health care fraud affects everyone. If you know of or suspect that fraud is taking place, contact:
CDPHP FRAUD AWARENESS HOTLINE at 1-800-280-6885

Addendum Policy

CDPHP acknowledges the need to addend a medical record in order to document the management for existing diagnoses related to that visit or for new diagnoses resulting from tests ordered during that encounter. Only the attending physician can amend the medical record and content must be based on an observation of the patient on the date of service and be signed by the observing physician. Examples include:

Late Entry: A late entry provides additional information that was omitted from the original entry. The late entry documents the current date and must be added within 15 days. A late entry is only acceptable if the provider of care has total recall of the omitted information and signs the late entry.

Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum must be within 30 days should be timely and bear the current date and reason for the addition or clarification of information and be signed by the person making the addendum. An example would be the addition of a notation documenting test results (lab, imaging, etc.) received after the original note was completed, as well as any patient care plan resulting from the new information.

Correction: When making a correction to the medical record, never write over or eliminate the original documentation whether on paper or in an electronic medical record. Any corrected record submitted must clearly show the specific change made, the date and time of the change, and the identity of the person making that entry. When a hard copy is generated from an electronic record, the records must show original notes as well as the correction.

"Corrections to the medical record legally amended prior to claims submission and/or medical review will be considered in determining the validity of services billed. If these changes appear in the record following payment determination based on medical review, only the original record will be reviewed in determining payment of services billed to Medicare." (https://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-amended-records

Adapted from Noridians interpretation of Medicare "established recordkeeping guidelines" Documentation Guidelines for Amended Medical Records. (2015, July 16). Retrieved April 10, 2017, from http://med.noridianmedicare.com.