Medical Records Documentation Standards

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Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM039**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

Reimbursement Guidelines

A. Legibility of Records

All entries must be legible to another reader to a degree that a meaningful review may be conducted. Please use care to ensure that records are not rendered illegible by poor handwriting or poor copy quality. If the records cannot be read after review by three different persons, the documentation (or any unreadable portion) is considered illegible. When illegible records are received, the services are considered not documented and therefore non-billable and will not be reimbursed.

Note: It is not acceptable to obscure portions of the record in any way (e.g., white-out, black-out marker, post-it note covering, etc.). This renders that portion of the record illegible and is an alteration of the medical record. When records are received with information obscured, services will be denied because:

- A portion of the records are illegible and/or unreadable.
- The records have been altered.
- We are unable to verify that we have complete and accurate information upon which to base our determination.

(This comment does not apply to sanitizing social security numbers or other non-medical HIPAA-protected information from the documents submitted.)

B. Providing Records for Review

The "burden of proof" remains with the provider to substantiate services and/or supplies billed.[7] All information required to support the codes and services submitted on the claim is expected to be in the member's medical record and be available for review. The provider submitting the claim is responsible for providing upon request all pertinent information and records needed to support the services billed. When the billing provider receives a letter or fax requesting information needed for an audit or review, if the requested documents and information are not received within the required timeframe, the record is deemed not to exist, and the services not documented. If the documentation is incomplete or insufficient to support the services, then the service or item will be considered as not documented.

Some providers choose to house test reports or other elements of the documentation at a different location from the office or facility. For example, the physician may bill for reading an EKG or X-ray performed in the hospital or the ASC/facility may bill the facility fees for a surgery but not keep a copy of the operative report. Because the billing provider is required to submit documentation to support billed charges upon request, it would be best practice if both the physician and the facility keep a copy of the relevant reports in their records so that it is readily available when needed.[20] Otherwise, your office is responsible for obtaining a copy of the needed records from the other location/provider and submitting them within the timeframe specified in the request.[43] When the response to a medical records request indicates the billing provider does not have a copy of the records to support the billed services/codes and instructs the health plan to contact another provider for the needed records, the services will be denied as not documented.

Any records, documentation or information not received in response to the original records request will not be considered at a later date. Please ensure that your response to records requests is both timely and complete.

When services are not documented or insufficiently documented, the record does not support the services were performed. Accordingly, services determined as not documented are denied to provider responsibility and the member may not be balance-billed for the items.[42] If the claim has already been adjudicated (e.g., claim already released, post-payment audit), the reimbursement is considered an overpayment, and a refund will be requested and the funds recovered.

C. Items Not Considered Part of the Medical Record

Supporting documentation for all billed services must be contained in the patient's written medical record. The following items are specifically not considered part of the medical record (not an all-inclusive list):

1. Notations on the claim.
   Any notations on the claim (e.g., size, dose, quantity, make, model, anatomical location, etc.) must be supported within the medical record itself.
2. Notations or comments on a fax cover sheet, records request letter, cover letter, etc. in lieu of records or accompanying the submitted records.
3. Phone statements.
   Any information provided in phone statements discussing a claim or billed services must be supported within the medical record itself.
4. Appointment books, schedules, ledgers, logs, charge capture reports, etc. (electronic or hardcopy).
5. Appeal letters and/or reconsideration requests.
   Appeal letters or reconsideration requests are useful to describe the basis for the appeal and reference supporting information. However, any information regarding the patient's condition and/or the services provided must be supported within the medical record itself.

D. Correct Reporting of Units

Units of service must be reported correctly.

Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician or facility should not report units of service for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service.[10]

E. Time-based Services

1. For any time-based procedure codes (codes with descriptions that specify an increment of time such as minutes or hours) the duration of the service must be clearly documented in the medical record. If the duration of the time-based service is not clearly and properly documented in the medical record, then the service is not supported due to incomplete documentation; the procedure code will be denied as not documented.
   a. Documentation in terms of "units" does not constitute documentation of time or duration. The actual number of minutes or begin-to-end times must be used.
   b. **At least or time ranges.** If a procedure code description says, "at least 20 minutes of clinical staff time" or specifies a range of time such as "20-35 minutes," then the procedure code may not be reported if less than the minimum amount of service time is documented (such as only 19 minutes).
   c. **Passing the mid-point.** When a procedure code description says "each 15 minutes" or "each hour" etc., then a unit of time is attained when the mid-point is passed.

i. Note that this rule does not apply to E/M services. The time given in the E/M code description is the minimum required time when coding E/M services based upon time.
ii. This "passing-the-mid-point" rule is consistent with the Medicare "8-minute rule" and CPT book guidelines on reporting time-based services.[6]

d. Time must be reported in full one-minute increments. Any fractions of less than one-minute will not be considered in the review.
e. If the time is documented with a range of time, only the lowest amount of time is supported in the record. Example: "Total time for performing exercises is 5 – 8 minutes." Only five (5) minutes is supported by this documentation.
f. If the amount of time the service was performed is less than 50% of the time described for the procedure code, then the service may not billed; it is considered incidental to any other services performed on that date.
g. When CPT guidelines for the use of a specific time-based code contain specific guidelines other than this, the specific code guidelines prevail.

2. Only one time-based code may be performed at a time. Because of this, if more than one procedure code is billed for the same date of service, to fully support all the billed services, the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.

3. Methods and examples for time documentation:
   a. <u>Acceptable:</u>
      i. Specific number of minutes. Example: "Manual therapy to lumbar spine x 15 minutes."
      ii. Listing begin-time and end-time for service. Example: "E-stim to cervical neck, 09:30 – 09:45."
   b. <u>Unacceptable:</u>
      i. Documenting time in terms of "units". Examples: "One unit of pulsed ultrasound was administered." or "Ther Ex 1 unit."
      ii. Documenting time using a range. Example: "Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms."
      iii. Documenting a quantity but not specifying the measurement or increment used. Example: "97110 Exercises x 2"
      iv. No time mentioned at all. Example: Checking or circling "NMR" or "TE" with no additional information documented.

F. Quantities and Measurements

1. Quantities and measurements must be specified in the documentation to support the codes and units of service billed.
   a. When quantities are not specified, the use of a singular noun or term supports a quantity of one. The use of a plural term (e.g., "lesions," "screws," "inches," "warts," "injections," etc.) will support more than one, but only two of that item or service and no more. For example:
      i. "Lesion" supports one lesion.
      ii. "Lesions" supports two lesions.
      iii. "Two lesions" supports two lesions.
      iv. "Three lesions" supports three lesions.
      v. "Four lesions" supports four lesions.
      vi. Etcetera.
   b. "Several" is not a specific quantity and is also considered a non-specific plural that supports only a quantity of two (2) for billing purposes.
   c. "A couple" designates a quantity of two (2) and no more, for billing purposes.

d. Documentation in terms of "units" or the CPT or HCPCS code does not constitute documentation of quantity or measurement. The number of inches (in), centimeters (cm), milliliters (ml), milligrams (mg), cubic centimeters (cc), etc. must be documented as the quantity, length, or measurement. That documentation will then be translated into the correct number of units to bill, based upon the quantity specified in the applicable code description.

   For example:

   The documentation states 205 mg of etoposide was given.
   Etoposide is billed with HCPCS code **J9181** (Injection, etoposide, 10 mg).
   205 mg given/10 mg per unit of J9181 = 20.5 units.
   20.5 units is rounded up to nearest whole unit = bill with J9181 x 21 units.

e. If quantities or measurements are documented with a statement of range (e.g., 2-3 inches), then only the lowest of the range stated is considered supported in the documentation.
f. Excision codes (Integumentary) – The measurement of lesion plus margin is made prior to excision. The measurement must be documented in the body of the operative report.
g. Repair (Closure) codes (Integumentary) – The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate. The measurement must be documented in the body of the operative report.
h. If no measurement of a lesion, defect repair, etcetera is documented, but it is clear that the procedure was performed on a structure of undocumented size, then only the procedure code for the smallest size available is supported by the medical record.

2. Some procedure codes do not specify a quantity or unit of measurement in the procedure definition, but the coding guidelines for the use or separate reimbursement of that service require some type of quantity or measurement to be included in the documentation of that service.

   For example:
   The American Academy of Orthopaedic Surgeons (AAOS) considers a claviculectomy (23120, 29824) performed in combination with other shoulder procedures to be separately billable only if "excision of the entire distal clavicle (approx 1 cm) is completed." Moda Health applies this guideline. If the amount or measurement of the clavicle removed is not documented, the service is not eligible for separate reimbursement, and any use of modifier 59 or XS is not supported.

G. Coding From The Operative Report or Procedure Note

Any statements or measurements listed in the "Procedure Performed" Title or Header section of the Operative Report or Procedure Note may not be used to support or select the billed procedure code.[31, 34, 35]

The body of the report must contain the details, descriptions, and measurements (e.g., lesion size, wound size, defect size, or amount of bone or tissue removed) needed to support that the requirements of the code have been met. The body of the operative report consists of the narrative description of what was performed and specifically how it was performed. If the "Procedure "Performed" indicates something that is not specified, supported, or included in the body of the operative report, then query the provider and have the body of the note amended before submitting the code and claim to the carrier.[35, 36]

If the claim has already been submitted and denied for lack of supporting information or detail in the body of the report, any amendments made to the record are for clinical clarification only. To resolve the denial, a corrected claim must be submitted with coding altered to match only the procedures and details supported in the body of the operative report or procedure note contained in the original medical record documentation.

H. Signature Requirements

Moda Health follows CMS and Noridian Medicare signature requirement guidelines.[7, 26, 27, 40, 41, 54]

1. All services provided to beneficiaries are expected to be documented in the medical records at the time they are rendered.
2. All medical record entries must include (among other things) the date of service, and a legible, dated, and timed signature of the provider.
3. Providers should not add late signatures to the medical record, other than those that result from the short delay that occurs during the transcription process.
4. If the signature is illegible, providers may submit a signature log or attestation to support the identity of the signer.[54]
5. If your facility doesn't have a signature log currently in place, Moda Health will accept all submitted signature logs regardless of the date they were created.
6. If the signature is missing, use the signature attestation process.[27, 54] The attestation must be signed and dated by the author of the medical record entry and contain sufficient information to identify the member and the specific encounter record involved.
7. For examples of specific signature situations which do and do not meet the signature requirements, refer to the chart provided by Noridian[7] and/or the Medicare Program Integrity Manual.[47]

I. Date of Service

The date of service on the claim must match the date of service in the medical record. Unless otherwise noted in a specific policy, we defer to CMS guidelines for date of service requirements.

J. Proof of Delivery (POD) Documentation

1. Moda Health follows CMS and Noridian Medicare proof of delivery documentation requirement guidelines. Proof of delivery is needed for any tangible supply or item which is not a professional service. This includes but is not limited to: DME, supplies, self-administered drugs, home infusion therapy supplies, orthotics, etc.[28,44,37, 45]

2. Methods of Delivery
   a. Delivery directly to the member/patient or authorized representative. Includes:
      i. Patient picks up the item at the office.
      ii. A supplier employee delivers the item to the member or designee at home or elsewhere (e.g., delivery via car, van, or truck).
   b. Delivery via shipping or delivery service.
   c. Delivery of items to a nursing facility on behalf of the member/patient.

3. Proof of delivery (POD) is a Supplier Standard. Suppliers are required to maintain proof of delivery documentation in their files, and to provide the documentation upon request.[28, 37,45, 63]
   a. Proof of delivery documentation provides verification that the provider properly coded the item(s), that the item(s) delivered are the same item(s) submitted on the claim for reimbursement and that the item(s) are intended for, and received by, a specific member.
   b. The POD documentation must:
      i. Clearly identify the item(s) being delivered so that the documentation can be correlated to support the specific procedure codes on the claim.[28, 63]
      ii. Indicate of the method of delivery.

c. Additional POD documentation requirements vary based on the method of delivery.
    i. If delivered directly to the member or designee:
        1) A dated signature of the member or designee indicating receipt or delivery of the item is needed.[44]
        2) Note that for PHE dates of service 3/1/2020 – 5/11/2023, if the member's signature could not be obtained because of COVID-19 then alternate documentation is acceptable in place of the member's dated signature.[49]
    ii. If delivered via shipping or delivery service, the supplier may use one of the following as proof of delivery documentation:
        1) The delivery service tracking and delivery document.
        2) A return postage-paid delivery invoice from the beneficiary or designee as POD. This type of POD document must contain the information specified above.[50]
    iii. If delivered to a nursing facility, POD must also include documentation from the nursing facility demonstrating receipt and/or usage of the item(s) by the member.

4. The date of service on the claim must match the date on the proof of delivery.
    a. For delivery directly to the patient or designee, the date of service is the date of the member's signature for receipt.
        Note that for PHE dates of service 3/1/2020 – 5/11/2023, if the member's signature could not be obtained because of COVID-19 then alternate documentation is acceptable in place of the member's dated signature.[49]
    b. For delivery via shipping or delivery service, the date of service is either:
        i. The date of delivery.
        ii. The date of shipment. The shipping date may either be:
            1) The date the delivery/shipping service label is created.
            2) The date the item is retrieved for delivery.
        However, such dates should not demonstrate significant variation.[37, 45]
    c. For delivery of items to a nursing facility (not using a shipping service), the date of service is the date of the staff's signature for receipt on behalf of the member.

K. Documentation of Orders For Tests and Services

1. Many services, both diagnostic and therapeutic, require physician/provider orders to be performed. For example, chest x-rays, CAT scans, EKGs, laboratory tests, issuing DME items, dispensing prescription medications, physical therapy, home infusion services, etc. This creates two distinct provider roles involved in the service:
    a. The ordering physician/provider.
    b. The performing and billing provider.

2. Performing/Billing Provider Responsibilities.
    a. It is important that performing providers review incoming orders and actively query the ordering provider as needed when there are concerns about medical necessity criteria and to ensure the diagnosis codes include all required characters (are complete) and are specific about the laterality and site of the patient's condition (no unspecified laterality or unspecified site diagnosis codes).
    b. Accurate and complete documentation of a valid and specific provider order for these services is an essential element of supporting documentation to verify the services for reimbursement purposes. The order for the services needs to identify the reason for the services ordered accurately and completely so that the claim can be submitted with diagnosis codes which:
        i. Support medical necessity.

ii. Meet correct coding requirements.
    1) Are complete (include all required characters).
    2) Are specific about laterality (no unspecified laterality diagnosis codes).
    3) Are specific about the site of the condition(s) (no unspecified site diagnosis codes).

c. When records are requested by Moda or one of our business associates/vendors:
    i. Per CMS, the billing provider whose claim is being reviewed is responsible to do the work to obtain all the needed supporting documentation from the referring physician, facility, or other providers if necessary, and then submit those records to the carrier or review organization.[51]
    ii. The billing provider may need to and is able to obtain records from visits prior to the date of service listed on the medical records request, if that is where the physician orders or other needed documentation is located.[51]

d. If records are requested for review, laboratory studies and other services which require a provider order that do not have a documented provider order as described below will be denied for lack of supporting documentation.

3. Ordering Physician/Provider Responsibilities.
    a. When ordering an item or service that will be furnished by another entity (e.g., a laboratory, radiology, DME service, etcetera), the ordering provider must supply to the performing provider adequate documentation supporting medical necessity for the ordered services, so that the performing provider can meet medical necessity coding and documentation requirements.[46]
        i. This information needs to be included on the order itself whenever possible. Additional documentation or medical records may be appended to the order for the item or service, if needed.
        ii. Ordering providers who fail to forward this needed information with the order for services or submit documentation upon a supplier's request may trigger coding and documentation reviews of their own claims for evaluation and management services.
    b. "Note: There are some circumstances for which an order does not need to be signed. As an example, orders for clinical diagnostic lab tests are not required to be signed. The rules in 42 CFR 410 and IOM Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature." [23, 24, 25]

        Comments to clarify terms in quote above:

        ["orders for clinical diagnostic lab tests" is equivalent to a requisition form.]

        ["must be authenticated by the author via a handwritten or electronic signature" means these documents must be signed and dated.]
    c. "Documentation and recordkeeping requirements… We clarified that we do not require the signature of the ordering physician on a requisition for laboratory tests. However, documentation that the physician ordered the test must be available upon our request." [23]

4. Requirements for orders & supporting documentation.
    a. We apply the same CMS requirements and exceptions from CMS 42 CFR 410[23], both to clinical diagnostic lab tests and to all other types of services requiring an order. Documentation that the treating physician ordered the test(s) must be available from the billing office/provider upon

request.[23] The billing office (clinical lab/pathologist, radiologist, etc.) has choices about which form or type of documentation they maintain or utilize to fulfill this requirement.

i. A requisition form signed and dated by the treating physician is one acceptable method of documenting the physician order.

ii. Instead of a signed and dated requisition form, the billing office may provide medical documentation by the treating physician showing that he/she intended the clinical diagnostic test be performed.
    1) (Examples include progress note, office visit note, operative report noting specimens submitted and tests requested.)
    2) Specific tests requested must be identified, not just "labs sent," "custom profile," etc.
    3) This alternative documentation from the treating physician's medical records must be signed and dated.

b. The full list of requirements and alternative acceptable documentation that the treating physician ordered the test(s) or service(s) is provided below.
   Provider orders must be:

   i. From a licensed provider who has evaluated the patient.

   ii. Signed and dated.
       1) Orders must be dated on or prior to the date of service.
       2) Verbal orders or telephone orders for a test or service may be countersigned by the physician after test or service has been performed if:
          a) The verbal/telephone order is fully documented with the date, time, name, and credentials of the person supplying and receiving the order and,
          b) The order is countersigned by the ordering provider as soon as possible after the verbal/telephone order, but no later than 30-days after the order was given.
       3) Electronic signatures from the ordering provider are acceptable in electronic health records.
       4) Electronic signatures from office staff working in the ordering provider's office are not acceptable.
       5) "Signature On File" is not acceptable as a valid signature from the provider. "Signature On File" is also not considered an electronic provider signature. Requisitions submitted with "Signature On File" are considered unsigned by the provider.
       6) If handwritten, the signature must be legible, or verifiable as the actual ordering provider's signature (for example, accompanied by copy of provider signature log).

   iii. Specific to an individual member and to the individual member's medical treatment plan.
       1) The order needs to include the member's name and any other means of identifying the member to be tested.
       2) Moda Health does not accept as appropriate documentation an order/requisition for a 'custom profile', or any similar document, used to establish general instructions for testing all patients of a physician or practice.

   iv. Specific regarding the test or services to be performed.
       Any orders or requisitions referring to the 'custom profile' or any similar document are not acceptable as appropriate documentation of an order because they do not specify or designate which individual tests are to be performed as part of the profile or custom panel.

   v. Orders for an ongoing series of regular tests and/or services shall be valid to support services for no longer than one year (365 days) from the date of the signed order. For additional tests or services in the series after the original order expires, an updated signed order will need to be obtained and kept on file.

vi. May be substantiated in the visit records if specific orders are documented in the visit notes and if the notes are signed. ("Order labs" is not specific, but "Order K+ level & lipid panel" is specific.) [24, 25]

vii. Supplied for review upon request.

L. Documentation for Psychological, Behavioral Health (BH), and Substance Use Disorder (SUD) Services

1. We follow documentation guidance from CMS, HIPAA and the American Psychological Association (APA).

2. When providing psychotherapy (whether alone or as part of a BH/SUD program), providers must strike a fine balance between patient privacy and clear, complete documentation of reported procedure codes.
   a. Psychotherapy notes receive special protection under HIPAA privacy rules. Unlike other medical records, psychotherapy notes require a patient's specific authorization for disclosure prior to releasing notes to the insurance carrier or other clinicians. Exceptions exist for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding the patient making threats of serious and imminent harm. [60]
   b. All billed codes must be fully supported in the medical record, which must be submitted upon request to validate the claim.

3. To ensure both above requirements are met, 45 CFR§164.501 (HIPAA) regulations outline how to document services when psychotherapy is provided. Two separate types of records must be maintained, with psychotherapy notes kept separated from the rest of the medical record containing other essential information. 60
   a. **Psychotherapy notes** are:
      i. Recorded by a mental health professional, documenting or analyzing the contents of a counseling session.[57]
      ii. Typically these notes are not required or useful for treatment, payment, or health care operations purposes.[60]
   b. **Medical record documentation of services** must be maintained in the medical record and be available upon request to validate procedure codes on the submitted claim. This portion of the medical record *excludes* psychotherapy notes and *includes* documentation of:
      i. Patient identification (name, account number, and other identifying data).
      ii. Date of service.
      iii. Counseling session start- and stop-times.
      iv. The modalities and frequencies of treatment are furnished.
      v. Results of clinical tests.
      vi. Medication prescription and monitoring, if applicable.
      vii. Summaries of:
         1) Diagnosis(es)
         2) Functional status
         3) Treatment plan(s)
         4) Symptoms, prognosis, and progress to date.
      viii. Name, signature, and credentials of the provider of service.

4. When we (or our vendor business parters covered under HIPAA law) request medical records of behavioral health or substance use disorder services, we are requesting the above medical records documentation of services to validate procedure codes. In the unlikely event psychotherapy notes are needed, the records request will specifically state "psychotherapy *notes*" rather than "medical records" for the services.

5. Neuropsychological testing (96132, 96133, 96136, 96137) [61, 62]
    a. These professional evaluation and testing services are typically spread out over multiple visits and involve different steps in the process. The group of visits and work involved to complete the process/service is called an "episode of care."
        i. For each step or visit, document the clinician or staff name, activities performed, the date, and the start and stop times. The summary of these visits will provide supporting documentation of the codes and units reported on the eventual claim.
        ii. Interactive feedback with the patient and/or family member(s) and caregiver(s) at the conclusion of the episode of care is expected to be a typical component of the process.
            1) The interactive feedback session is included in the reimbursement for the service/episode of care.
            2) Do not report a separate visit or E/M for this feedback session.
        iii. The cumulative time spent performing the steps in the process is totaled at the conclusion of the episode of care.
    b. The primary/base code and the appropriate number of units of the add-on code for the total cumulative time is billed.
    c. The date of service (DOS) on the claim is the date the episode of care concluded. [61]
    d. The American Psychological Association (APA) has described five (5) stages of an episode of care in this scenario. The tasks in stages 2, 3, and 4 do not necessarily need to be provided in this exact order. The stages are:
        i. Stage 1
            - Record review and clarification of referral question.
            - Initial test selection.
        ii. Stage 2
            - Psychiatric Diagnostic Evaluation/Neurobehavioral Status Examination.
            - Modification of initial test selection based on clinical interview findings.
        iii. Stage 3
            - Test Administration and Scoring.
                - 3A: By Professional.
                - 3B: By Technician.
        iv. Stage 4
            - Integration/Report Generation
        v. Stage 5
            - Feedback session with patient (and family/caregiver).
            - Feedback to the referring physician.

e. Example of medical records and claim for Neuropsychological Testing Evaluation Services (Adapted & excerpted from the APA's Detailed Case Example 2 [62]):

i. Medical records documentation for the episode of care includes, at a minimum:

Date	Time	Service	# Minutes
DATE Day 1	9:00 – 9:05 AM	Record review and clarify referral question	5 minutes
DATE Day 1	10:20 – 10:30 AM	Intra-session clinical decision making	10 minutes
DATE Day 1	10:30 – 10:45 AM	Patient symptom management	15 minutes
DATE Day 1	10:45 – 10:55 AM 2:10 – 2:20 PM	Clinical decision making/battery modification	30 minutes
DATE Day 2	10:00 AM – 12:00 PM	Integration/report generation	120 minute
DATE Day 3	10:00 – 11:00 AM	Interactive feedback session to patient & family	60 minutes
DATE Day 3	11:35 – 11:40 AM	Post-service work	5 minutes
		Total Time for episode of care:	245 minutes (4 hours 5 minutes)

Provider of service name, signature, and credentials. Date signed, time signed

ii. The claim for the above example episode of care lasting 4 hours and 5 minutes is as follows:

DOS	Procedure Code	# of Units	Total Time
DATE Day 3	Base: 96132 (1st 60 minutes)	1	60 minutes (one hour)
DATE Day 3	Add-on: 96133 (each add'l 60 minutes)	3	180 minutes (three hours)
--	No code; do not report, midpoint of another hour of service has not been passed.	--	Last 5 minutes

M. Cloning of Medical Records

1. Cloned medical records entries are not reliable as an accurate record of the events and services depicted. All documentation in the medical record must:
   a. Be specific to the patient.
   b. Be specific to the situation at the time of the encounter.
   c. Accurately reflect the services performed.
   d. Support the necessity for the services.
   e. Clearly identify who performed the services and assessments documented.
   f. Clearly identify the author of each note or entry.
   g. Clearly identify the date and time the entry was made.
2. Services are considered not documented when cloned documentation is found or identified, and services will be denied due to the lack of supporting documentation. If services have previously been allowed, refund requests and recoupment of payment may occur.
3. Cloned documentation is considered a misrepresentation of the events and services in that entry and a falsification of the medical record;[12] the accuracy and validity of the entire entry is damaged. Other entries in the record may also become suspect.[22]
4. Medical records documentation is considered cloned when:
   a. Multiple entries in a patient chart are identical or similar to other entries in the same chart.
   b. Entries in the medical record are identical or similar from patient to patient to patient, without expected unique variations. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

c. Information from previous entries of the same provider or other providers is pulled forward into the current entry, particularly when it is not updated or not relevant to the current encounter.
d. In other words, copying and pasting, pulling forward information, and the use of macros or templates could all be considered cloning.

5. Over-documentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services.[11] Vast amounts of clinical data and whole text from previous notes or the initial history and physical do not add value or clarity to the medical record; the story of the patient and the services becomes muddled and obscured under a deluge of clinical information that may not even be relevant or current.

6. Although the problem has certainly become more prevalent with the advent and increased use of electronic medical records systems (EHR/EMR), cloning of medical records can occur in all types of medical record formats (handwritten, dictated, typed, and electronic).

N. Records Considered for Review

1. The following documentation *will* be considered when determining the validity of services billed and the processing of the claim:
   a. Documentation submitted for the initial review and part of the original medical record.
      (Note: Phone statements, appeal letters, reconsideration requests, notations on the claim, etc. are not considered part of the original medical record.)
   b. Corrections to the medical record will be considered when *all* the following criteria are met:
      i. Legally amended.
         Note:
         For guidelines regarding legal corrections and amendments to medical records, please see "Documentation Guidelines - Amended Records," which is attached at the end of this document.[1, 39, 40]
      ii. Amended within 30-days of date of service (outpatient) or date of discharge (inpatient). [5, 8, 9, 52]
      iii. Amended prior to claims submission and/or medical review.
      iv. Amendment contains signature, date of amendment, and reason for the addition or clarification of information being added to the medical record.[1, 39, 40]

2. The following documentation *will not* be considered when determining the validity of services billed and the processing of the claim:
   a. Changes or amendments which appear in the record more than 30-days after the date of service/discharge.
   b. Changes or amendments made after a records request.
   c. Changes or amendments made after a payment determination.
   d. Medical records with information obscured or blocked in some manner (e.g., white-out, black-out marker, etc.)
   e. Documentation or statements which is/are not part of the medical record.
      i. Phone calls or other verbal statements.
      ii. Statements in appeal letters or other written documentation made in lieu of corrections or amendments to the medical record.

O. Reconsiderations and Appeals

Appeal of claims denied based on an incomplete record *may* result in a reversal of the original denial if the information supplied includes pages or components that were part of the original medical record but were not submitted on the initial review.

Definitions

Acronyms/Abbreviations

Acronym	Definition
AAOS	American Academy of Orthopaedic Surgeons
AMA	American Medical Association
APA	American Psychological Association
CAT	Computerized Axial Tomography
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DOS	Date of Service
EHR/EMR	Electronic Health Record, Electronic Medical Record
EKG/ECG	Electrocardiogram
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MAC	Medicare Administrative Contractor
NCCI	National Correct Coding Initiative (aka "CCI")
OIG	Office of Inspector General
POD	Proof of Delivery
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
TAC	Texas Administrative Code

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Modifier 52 – Reduced Services." Moda Health Reimbursement Policy Manual, RPM003.
C. "Records Fees, Copying Fees." Moda Health Reimbursement Policy Manual, RPM005.
D. "Clinical Drug Screening and/or Drug Testing." Moda Health Reimbursement Policy Manual, RPM016.
E. "Modifier 63 - Procedure Performed on Infants Less Than 4 kg." Moda Health Reimbursement Policy Manual, RPM062
F. "Supply Limits For Ongoing Medical Supplies." Moda Health Reimbursement Policy Manual, RPM072.

Resources

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Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
6/10/2026	Clarified documentation requirements for psychological counseling & testing & related services. Acronyms & Resources updated. Formatting updates. No policy changes.
3/12/2025	Clarifying details added to Time-based Services. Related Policies updated. Formatting updates. No policy changes.
6/12/2024	Clarified 1) coding supported when lesion/structure size is not documented, 2) date of service billing requirements. Coding Guidelines & Resources updated. No policy changes.
11/8/2023	Clarified billing provider responsibilities for providing records from CMS guidelines. Formatting updates. No policy changes.
10/11/2023	Clarified one time-based service at a time. Clarified ordering provider is responsible to ensure diagnosis codes on orders are complete and specific to laterally and site. No policy changes.
6/15/2023	Clarified Proof of delivery options. No policy changes.
4/12/2023	Clarified options for date of delivery with shipping/delivery of items. No policy changes.
10/13/2022	Idaho added to Scope. Formatting updates. No policy changes.
6/8/2022	Clarified "Charge capture reports" are not part of the medical record to support billed codes. Formatting updates. Policy History entries prior to 2022 omitted (in archive storage). No policy changes.
10/9/2014	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on CMS, CPT, and industry standard documentation and medical records standards and requirements. (See entire References & Resources section listings.)

Attachment

Heading: Reminder
Title: Documentation Guidelines - Amended Records

This article from *"Medicare B News,"* Issue 207 dated October 14, 2003 is being reprinted as a reminder to insure that the Noridian Administrative Services' provider and supplier community has access to recent publications that contain the most current, accurate and effective information available.

Medical Review Payment Decisions

Incomplete or illegible records can result in denial of payment for services billed to Medicare. Claim payment decisions that result from a medical review of your records are not a reflection on your competence as a health care professional or the quality of care you provide to your patients. Specifically, the results are based on review of the documentation that Medicare received.

In order for a claim for Medicare benefits to be valid, there must be sufficient documentation in the provider's or hospital's records to verify the services were performed, were "reasonable and necessary", and required the level of care that was delivered.

Please understand that Medicare is aware that some patients do require professional services at greater frequency and duration than others, including more extensive diagnostic procedures. When this is the case, documentation substantiating the medical necessity for such treatment must be in the medical record. The documentation of all services rendered is absolutely necessary in order for a claim to be properly evaluated.

If there is no documentation, then there is no justification for the services or level of care billed. Additionally, if there is insufficient documentation on the claims that have already been adjudicated by Medicare, reimbursement may be considered an overpayment and the funds can be partially or fully recovered.

Elements of a Complete Medical Record

When records are requested, it is important that you send all associated documentation that supports the services billed within the timeframe designated in the written request. Elements of a complete medical record may include:

- Physician orders, and/or certifications of medical necessity
- Patient questionnaires associated with physician services
- Progress notes of another provider that are referenced in your own note
- Treatment logs
- Related professional consultation reports

- Procedure, lab, x-ray and diagnostic reports

Amended Medical Records

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum, or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.

A **late entry** supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible and written only if the person documenting has total recall of the omitted information.

Example: A late entry following treatment of multiple trauma might add: *"The left foot was noted to be abraded laterally."*

An **addendum** is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record.

Example: An addendum could note*: "The chest x-ray report was reviewed and showed an enlarged cardiac silhouette."*

When making a **correction** to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time and reason for the change. When a hard copy is generated from an electronic record, both records must be corrected. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Falsified Documentation

Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or

- Adding to existing documentation (except as described in late entries, addendums and corrections)

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.

Appeal of claims denied on the basis of an incomplete record may result in a reversal of the original denial if the information supplied includes pages or components that were part of the original medical record, but were not submitted on the initial review.

Applies to the states of: AK, AZ, CO, HI, IA, NV, ND, OR, SD, UT, WA and WY.

Sources: Medicare B News, Issue 196, dated April 15 2002: "Documentation Guidelines for Medicare Services"

§1833(e) Title XVIII of the Social Security Act (No Documentation)

§1842(a)(1)(c) of the Social Security Act (Carrier Audits)

§1862(a)(1)(A) of Title XVIII of the Social Security Act (Medical Necessity)

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