



**Manual:** Reimbursement Policy

**Policy Title:** **Medical Records Documentation Standards**

**Section:** Administrative

**Subsection:** None

**Date of Origin:** 1/1/2000                      **Policy Number:** RPM039

**Last Updated:** 5/4/2018                      **Last Reviewed:** 8/10/2018

---

### **Scope**

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

### **Reimbursement Guidelines**

#### 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 cannot 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 may 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.)

#### Providing Records for Review

The "burden of proof" remains with the provider to substantiate services and/or supplies billed. (*Noridian Medicare*<sup>7</sup>) 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.

At times 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. (FCSO Medicare <sup>20</sup>) 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. 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 or discovered after the review is complete will be considered for possible reconsideration of the audit review only at Moda Health's sole discretion. Please ensure that your response to records requests is both prompt and complete.

When services (procedure codes) are not documented or insufficiently documented, the record does not support that the services were performed and so they are not billable; there is no justification for the services or level of care billed. Therefore, services that are determined to be not documented are denied to provider responsibility and the member should not be balance-billed for the items. If the claim has already been adjudicated (e.g., claim already released, postpayment audit), the reimbursement is considered an overpayment and a refund will be requested and the funds recovered if necessary.

#### 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):

- 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.
- Notations or comments on a fax cover sheet, records request letter, cover letter, etc. in lieu of records or accompanying the submitted records.

- Phone statements.  
Any information provided in phone statements discussing a claim or billed services must be supported within the medical record itself.
- Appointment books, schedules, ledgers, logs, etc. (electronic or hardcopy).
- 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.

### 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. (*NCCI Policy Manual*<sup>10</sup>)

### Time-based Services

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.

- 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.
- A unit of time is attained when the mid-point is passed. (This is consistent with the Medicare "8-minute rule" and CPT book guidelines on reporting time-based services.<sup>6</sup>)
- Time must be reported in full one-minute increments. Any fractions of less than one-minute will not be considered in the review.
- If the time is documented with a range of time, only the lowest amount of time is considered to be supported in the record. Example: "Total time for performing exercises is 5 – 8 minutes." Only five (5) minutes is supported by this documentation.
- If the amount of time the service was performed is less than 50% of the time described for the procedure code, then the service will not be separately reimbursable, but will be considered incidental to the other services performed on that date.

If more than one procedure code is billed for the same date of service, then in order to fully support all of 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.

Methods and examples for time documentation:

Acceptable:

- Specific number of minutes. Example: “Manual therapy to lumbar spine x 15 minutes.”
- Listing begin-time and end-time for service. Example: “E-stim to cervical neck, 09:30 – 09:45.”

Unacceptable:

- Documenting time in terms of “units”. Examples: “One unit of pulsed ultrasound was administered.” or “Ther Ex 1 unit.”
- Documenting time using a range. Example: “Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms.”
- Documenting a quantity but not specifying the measurement or increment used. Example: “97110 Exercises x 2”
- No time mentioned at all. Example: Checking or circling “NMR” or “TE” with no additional information documented.

Quantities and Measurements

Quantities and measurements must be specified in the documentation to support the codes and units of service billed.

- 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:
  - “Lesion” supports one lesion.
  - “Lesions” supports two lesions.
  - “Two lesions” supports two lesions.
  - “Three lesions” supports three lesions.
  - “Four lesions” supports four lesions.
  - Etcetera.
- “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.
- “A couple” designates a quantity of two (2) and no more, for billing purposes.
- 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.

- 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.
- 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.
- 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.

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 claviclectomy (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.

#### 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. (AMA<sup>31</sup>, HCPro<sup>34, 35</sup>)

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. (<sup>35</sup>, Edwards<sup>36</sup>)

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. In order 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.

## Signature Requirements

Moda Health follows CMS and Noridian Medicare signature requirement guidelines.

- All services provided to beneficiaries are expected to be documented in the medical records at the time they are rendered.
- All medical record entries must include (among other things) the date of service, and a legible, dated, and timed signature of the provider.
- 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.
- If the signature is illegible, providers may submit a signature log or attestation to support the identity of the signer.
- 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.
- If the signature is missing, use the signature attestation process. (CMS<sup>27</sup>) 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.
- For examples of specific signature situations which do and do not meet the signature requirements, refer to the chart provided by Noridian (<sup>7</sup>).

(Noridian Medicare<sup>7</sup>, Noridian Medicare<sup>26</sup>, CMS<sup>27</sup>)

## Proof of Delivery (POD) Documentation

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.

### Methods of Delivery

- Delivery directly to the member/patient or authorized representative (includes patient pick-up at the office).
- Delivery via shipping or delivery service.
- Delivery of items to a nursing facility on behalf of the member/patient.

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. (Noridian Medicare<sup>28</sup>)

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. The documentation should always include:

- A sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description). The long description of the HCPCS code, may be used

as a means to provide a detailed description of the item being delivered. (Noridian Medicare<sup>28</sup>)

- A dated signature of the member or designee indicating receipt or delivery of the item.
- Indication of the method of delivery.
- 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.

The date of service on the claim must match the date on the proof of delivery.

- For delivery directly to the patient or designee, the date of service is the date of the member's signature for receipt.
- For delivery via shipping or delivery service, the date of service is the date of shipment.
- 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.

#### Documentation of Orders For Tests and Services

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, etc. Accurate and complete documentation of a valid and specific provider order for these services (e.g. laboratory testing) is an essential element of supporting documentation to verify the services for reimbursement purposes.

**“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.” (CMS<sup>23</sup>) (CMS<sup>24</sup>) (Noridian Medicare<sup>25</sup>)

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.]

“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.” (CMS 42 CFR 410<sup>23</sup>, page 4)

Moda Health applies the same CMS requirements and exceptions from CMS 42 CFR 410<sup>23</sup>, 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. (CMS 42 CFR 410<sup>23</sup>) 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.

- A requisition form signed and dated by the treating physician is one acceptable method of documenting the physician order.
- 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.
  - (Examples include progress note, office visit note, operative report noting specimens submitted and tests requested.)
  - Specific tests requested must be identified, not just “labs sent,” “custom profile,” etc.
  - This alternative documentation from the treating physician’s medical records must be signed and dated.

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:

- From a licensed provider who has evaluated the patient.
- Signed and dated.
  - Orders must be dated on or prior to the date of service.
  - Verbal orders or telephone orders for a test or service may be countersigned by the physician after test or service has been performed if:
    - The verbal/telephone order is fully documented with the date, time, name, and credentials of the person supplying and receiving the order and,
    - 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.
  - Electronic signatures from the ordering provider are acceptable in electronic health records.
  - Electronic signatures from office staff working in the ordering provider’s office are not acceptable.
  - “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.
  - 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).
- Specific to an individual member and to the individual member’s medical treatment plan.
  - The order needs to include the member’s name and any other means of identifying the member to be tested.
  - 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.



- Specific regarding the test or services to be performed.  
Moda Health does not accept as appropriate documentation any orders or requisitions referring to the 'custom profile', or any similar document, as the means of designating which tests are to be performed.
- 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.
- 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.) (CMS 42 CFR 410<sup>23</sup>, page 4) (CMS<sup>24</sup>) (Noridian Medicare<sup>25</sup>)
- Supplied for review upon request.

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 above will be denied for lack of supporting documentation.

#### Cloning of Medical Records

Cloned medical records entries are not reliable as an accurate record of the events and services depicted. All documentation in the medical record must:

- Be specific to the patient.
- Be specific to the situation at the time of the encounter.
- Accurately reflect the services performed.
- Support the necessity for the services.
- Clearly identify who performed the services and assessments documented.
- Clearly identify the author of each note or entry.
- Clearly identify the date and time the entry was made.

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.

Cloned documentation is considered a misrepresentation of the events and services in that entry and a falsification of the medical record (FCSO Medicare <sup>12</sup>); the accuracy and validity of the entire entry is damaged. Other entries in the record may also become suspect. (OMB <sup>22</sup>)

Medical records documentation is considered cloned when:

- Multiple entries in a patient chart are identical or similar to other entries in the same chart.
- 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.
- 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.
- In other words, copying and pasting, pulling forward information, and the use of macros or templates could all be considered cloning.

Over-documentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services. (OIG <sup>11</sup>) 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.

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).

#### Records Considered for Review

The following documentation *will* be considered when determining the validity of services billed and the processing of the claim:

- 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.)
- Corrections to the medical record will be considered when *all* of the following criteria are met:
  - 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. (*Noridian Medicare*<sup>1</sup>)
  - Amended within 30-days of date of service (outpatient) or date of discharge (inpatient). (*The Joint Commission*<sup>8,9</sup>)
  - Amended prior to claims submission and/or medical review.
  - Amendment contains signature, date of amendment, and reason for the addition or clarification of information being added to the medical record.

(*Noridian Medicare*<sup>1</sup>)

The following documentation *will not* be considered when determining the validity of services billed and the processing of the claim:

- Changes or amendments which appear in the record more than 30-days after the date of service/discharge.
- Changes or amendments made after a records request.
- Changes or amendments made after a payment determination.
- Medical records with information obscured or blocked in some manner (e.g. white-out, black-out marker, etc.)
- Documentation or statements which is/are not part of the medical record.
  - Phone calls or other verbal statements.
  - Statements in appeal letters or other written documentation made in lieu of corrections or amendments to the medical record.

Reconsiderations and Appeals

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.

**Background Information**

All healthcare entities and providers are required to keep medical records. These records are a legal document, which serves both clinical needs and to substantiate the services and items billed on the claim submitted.

Incomplete or illegible records can result in denial of reimbursement for services billed. Claim payment decisions that result from a medical review of records are not a reflection on the provider’s competence as a health care professional or the quality of care provided to the patient/member. Specifically, the results are based on review of the documentation that was received.

**Codes, Terms, and Definitions**

Acronyms Defined

Acronym		Definition
AAOS	=	American Academy of Orthopaedic Surgeons
CAT	=	Computerized Axial Tomography
CFR	=	Code of Federal Regulations
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DME	=	Durable Medical Equipment

Acronym		Definition
EHR	=	Electronic Health Record
EKG / ECG	=	Electrocardiogram
EMR	=	Electronic Medical Record
EOCCO	=	Eastern Oregon Coordinated Care Organization
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
ICD-10-CM	=	International Classification of Diseases, 10 <sup>th</sup> Revision, Clinical Modification
NCCI	=	National Correct Coding Initiative
OIG	=	Office of Inspector General
POD	=	Proof of Delivery

### Coding Guidelines

“Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code.” (*CPT Code Book*<sup>2</sup>)

When submitting claims to the carrier, procedure codes are to be selected based upon the services documented in the patient’s medical record at the time of code selection. “The CPT/ICD-9 codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.” (*CPT Assistant*<sup>3</sup>)

“The medical record chronologically documents the care of the patient in order to...facilitate claims review and payment...and...serve as a legal document to verify the care provided.” (*CPT Assistant*<sup>3</sup>)

“The medical record should be complete and legible.” (*CPT Assistant*<sup>2</sup>)

“Because payers have a contractual obligation to enrollees, they may request additional documentation to validate that services provided were:

- appropriate to the treatment of the patient's condition;
- medically necessary for the diagnosis and/or treatment of an illness or injury; and
- coded correctly.” (*CPT Assistant*<sup>3</sup>)

**“Question:**

How does HCFA feel about templates for physicians to use when dictating exams? These would be physician prompts to comment upon the mandated elements of the exam, not actual verbiage that would "spit out" with the striking of a single key?

**Answer/AMA Comment:**

HCFA is opposed to templates for physicians to use when dictating exams, because the minimum requirements of the Documentation Guidelines does not preclude adherence to other physician, institutional, and/or medical record documentation requirements.” (*CPT Assistant*<sup>4</sup>)

“Medical records not only must be accurate, but also must be completed in a timely manner. Entries to the record should be made when the treatment they describe is given or when the observations to be documented are made. Specific legal requirements that entries be made within a certain time following a patient’s discharge also exist. Regulations on participation in federal reimbursement programs, for example, require that hospital records be complete within 30 days following the patient’s discharge....Joint Commission standards of accreditation for a variety of healthcare organizations also impose timeliness as a standard for gathering medical records data.” (*Roach, et al*<sup>5</sup>)

“Corrections to records, although perfectly permissible, can create serious problems, especially for a healthcare provider involved in negligence litigation. Even if the correction improves the accuracy of the record, a correction can generate difficulties if it is improperly made, deteriorates legibility, or cannot be authenticated. In addition, any alterations made simply to improve the defense of a lawsuit or to defraud third-party payers can have serious consequences for a healthcare provider, including the imposition of criminal sanctions. For all these reasons, therefore, a healthcare provider’s medical records policy should address the timeliness and manner for both creating and updating patient records.” (*Roach, et al*<sup>5</sup>)

“In addition, entries that are not contemporaneous with the service provided are less likely to be accurate, and therefore will have less credibility than those made during or immediately after the treatment. If an entry is made after a lawsuit has been threatened or filed, late entries may appear to have been made for the self-serving purposes of establishing a defense rather than for documenting the actual treatment rendered.” (*Roach, et al*<sup>5</sup>)

“A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed.” (*AMA*<sup>6</sup>)

“Documentation in the medical record is entered in a timely manner...The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after discharge.” (*The Joint Commission*<sup>8,9</sup>)

“Physicians must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician should not report units of service for a HCPCS/CPT code using a criterion that differs from the code’s defined unit of service.” (*NCCI Policy Manual*<sup>10</sup>)

“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.” (CMS 42 CFR 410<sup>23</sup>, page 4)

*“Response [to public comments of proposed rule]:* Regulations set forth at § 410.32(a) require that diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary’s specific medical problem. Some have interpreted this regulation to require a physician’s signature on the requisition as documentation of the physician’s order. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the test, it is not the only permissible way of documenting that the test has been ordered. For example, the physician may document the ordering of specific tests in the patient’s medical record. As stated in the preamble to the March 10, 2000 proposed rule, we will publish an instruction to Medicare contractors clarifying that the signature of the ordering physician is not required for Medicare purposes on a requisition for a clinical diagnostic laboratory test....Authorization does not equate to physician signature; the CLIA regulations provide, for example, that the patient’s chart or medical record may be used as the test requisition. The CLIA regulations address this written authorization as a means of ensuring that laboratories are not performing tests that were not authorized. They do not address or conflict with the requirement that there be documentation of the physician’s order available upon request of the Medicare contractor. Of course, if the physician signs the requisition himself, it would satisfy both the requirement in § 410.32(a) and § 405.1105.” (CMS 42 CFR 410<sup>23</sup>, page 16)

“Clarification the signature is not required on requisition as contained in section III.D.3 of the proposed rule.” (CMS 42 CFR 410<sup>23</sup>, page 21)

**“NOTE:** No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services;... While a physician order is not required to be signed, the physician must clearly document, in the medical record, his or her intent that the test be performed.” (CMS<sup>23</sup>)

“If the order is communicated via telephone, both the treating physician/practitioner or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary’s medical records.” (CMS<sup>24</sup>)

**“Q18. If a lab requisition form is dated and includes a valid legible provider signature, is that considered a valid order?”**

A18. Yes, it would be considered valid for the signature requirement; however, the test is subject to medical necessity by the provider's intent that the clinical diagnostic test should be performed.

**Q19. To clarify clinical lab reports and the signature requirements, should the reports be signed by the ordering provider or the lab director?**

A19. The order should be authenticated by the provider via a handwritten or electronic signature.

**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.” (Noridian Medicare<sup>25</sup>)

“Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.” (FCSO Medicare <sup>12</sup>)

“If a provider’s notes contain a laundry list of the patient’s chronic and acute conditions, the structural integrity of the note — which is supposed to represent what happened during the specific visit — becomes compromised. The assessment and plan should reflect the problems addressed that day, with a status update. The documentation guidelines before EHRs did not allow using and updating a previous assessment and plan. Until CMS updates or changes the guidelines, the rules still stand (CMS 1995 and 1997 *Documentation Guidelines for Evaluation and Management Services*).” (Hall <sup>13</sup>)

**“Beware the point-and-click....**Second, the Board has seen cases in which the practitioner cannot resist the temptation to click on an exam box to qualify for a level of service when the exam was, in fact, not done. In cases that have been reviewed by the Board, these fabrications are usually obvious and have the effect of calling into the question the integrity of the licensee as well as the entire medical record.” (OMB <sup>22</sup>)

**“Beware the cut-and-paste.** Most EMR systems offer a macro with which the physician, with a mouse click, can enter an entire operative report or a copy of the previous office note. Again, the integrity of the entire medical record is weakened when factual inaccuracies are perpetuated through a macro.” (OMB <sup>22</sup>)

“2) Look at the top of the operative report where it indicates the operation performed...As you read through the operative report, highlight the procedures that are described. **Sometimes there are additional procedures which may be coded; sometimes the procedures listed at the top of the operative report were not performed.** Report only those services that are documented in the

operative report. If there is a discrepancy, ask the physician to review your coding to ensure that it is accurate. ...

8) Code only the procedure(s) in the operative report you verified in step two. If in your discussion with the physician, he/she indicates that additional procedures were performed that are not reflected in the operative report, ask the physician to dictate an addendum to the operative report describing the performance of the additional procedure(s).” (AMA<sup>31</sup> bold font contained in original AMA text)

“The title of the procedure is a brief description of what procedures the physician performed and helps coders know what is going on. This should be a total listing of what the physician did, but does not determine whether the item can be coded and billed, Pegram said. Coders should never code from the title of the procedure.” (HCP<sup>34</sup>)

“Warning: Do not code procedures from the outline in the report! These headings are merely previews of what is to come. Regardless of what the heading says, for a procedure to be eligible for reimbursement, it must be documented in the body of the report.” (35)

“Remember: The documentation for the procedure should always be described in the body of the report. If the body of the report does not contain something that is mentioned in the heading, then the physician must correct the documentation before it can be reported. Remember the mantra of the medical coder: “If the doctor didn’t say it, it wasn’t done.” (35)

“The operative note is the full report of what the surgeon performed during surgery. What do you do if the “procedures performed” indicates something that is not included in the body of the operative report? Query the provider.” (Edwards<sup>36</sup>)

## Cross References

- A. “Modifier 52 – Reduced Services.” Moda Health Reimbursement Policy Manual, RPM003.
- B. “Records Fees, Copying Fees.” Moda Health Reimbursement Policy Manual, RPM005.
- C. “Clinical Drug Screening and/or Drug Testing.” Moda Health Reimbursement Policy Manual, RPM016.

## References & Resources

1. Noridian Medicare. “Documentation Guidelines - Amended Records.” *Medicare B News*, Issue 207, October 14, 2003. June 27, 2014  
<[https://www.noridianmedicare.com/provider/updates/docs/doc\\_Guides\\_amend\\_records\\_reprint.pdf](https://www.noridianmedicare.com/provider/updates/docs/doc_Guides_amend_records_reprint.pdf)>. **See Attachment at end of this list.**
2. American Medical Association. “Instructions for Use of the CPT Codebook.” *Current Procedural Terminology (CPT), Introduction*. Chicago: AMA Press.



3. American Medical Association. "Coding Clarification: Principles of Documentation", *CPT Assistant*, Summer 1992, page 21.
4. American Medical Association. "Coding Consultation: Documentation Guidelines, No Use of Templates (Q&A)", *CPT Assistant*, January 1998, page 11.
5. Roach, William H. Jr., MS, JD; Hoban, Robert G., JD; Broccolo, Bernadette M., JD; Roth, Andrew B., JD; Blanchard, Timothy P., MHA, JD. *Medical Records and the Law*. American Health Information Management Association (AHIMA). Sundbury, MA: Jones and Bartlett Publishers, 2006.
6. American Medical Association. "Time." *Current Procedural Terminology (CPT), Introduction*. Chicago: AMA Press.
7. "Documentation Guidelines for Medicare Services." *Noridian Medicare*. September 15, 2013. May 18, 2017 < <https://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-medicare-services> >
8. "Record of Care, Treatment, and Services; Timeliness, RC.01.03.01." *The Joint Commission* (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO)) *Hospitals (CAMH) Program Manual*. 2012: August 6, 2014. [http://www.uhnj.org/mdstfweb/The\\_Joint\\_Commission/Record%20of%20Care%20Treatment%20%20Services.pdf](http://www.uhnj.org/mdstfweb/The_Joint_Commission/Record%20of%20Care%20Treatment%20%20Services.pdf)
9. "Authentication of Documentation." *The Joint Commission*. FAQ, Record of Care, Treatment, and Services (CAMH / Hospitals). November 24, 2008: August 6, 2014. <[http://www.jointcommission.org/standards\\_information/jcfaqdetails.aspx?StandardsFAQId=8&StandardsFAQChapterId=79](http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=8&StandardsFAQChapterId=79)>.
10. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § A.
11. OIG. "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology." (Report OEI-01-11-00570) December 2013. April 2015. < <https://oig.hhs.gov/oei/reports/oei-01-11-00570.pdf>>.
12. FCSO Medicare. "Cloning of Medical Notes." *The Florida Medicare B Update*, third quarter 2006 (vol. 4, no. 3), pg. 4.
13. Hall, Kellie S., CPC, CPCO, CCS-P. "Cloning: Address the Elephant in the Room." *AAPC Healthcare Business Monthly Archive*. March 2015. April 2015. < <http://news.aapc.com/cloning-address-the-elephant-in-the-room/>>.

14. Cueva, Juan P., MD. "EMR Cloning: A Bad Habit." *Chicago Medical Society, News*. 2014. April 2015. <<http://www.cmsdocs.org/news/emr-cloning-a-bad-habit>>.
15. Tews, Ronda, CPC, CHC, CCS-P. "Set Up Templates So Cloning Is Not Questioned." *AAPC Healthcare Business Monthly Archive*. June 2014. April 2015. <<http://news.aapc.com/set-up-templates-so-cloning-is-not-questioned/>>.
16. Will, Joyce, RHIT, CPC. "Win the Battle of the Clones." *AAPC Healthcare Business Monthly Archive*. November 2013. April 2015. <<http://news.aapc.com/win-the-battle-of-the-clones/>>.
17. "HHS and DOJ Issue Joint Letter on Cloning of Medical Records." *SCAN Health Plan*. October 2012. April 2015. <<http://hccublog.scanhealthplan.com/2012/10/hhs-and-doj-issue-joint-letter-on.html>>.
18. HHS & DOJ. "Joint Letter on EHR Fraud Concerns." September 2012. April 2015. <<http://www.hccuniversity.com/documents/hcc/tools/HHS%20DOJ%20Letter%20on%20Cloning.pdf>>.
19. "Medical Record Cloning." Palmetto GBA, Medicare Jurisdiction 11 Part B. October 2014. April 2015. <<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Jurisdiction-11-Part-B~8MKQK88358>>.
20. FCSO Medicare. "Documentation." *The Florida Medicare B Update*, third quarter 2006 (vol. 4, no. 3), pg. 3.
21. Prasad, Alok. "5 Ways to Prevent Fraud When Using an EHR." *MedCityNews.com*. February 2015. April 2015. <<http://medcitynews.com/2015/02/5-ways-to-prevent-ehr-fraud/>>.
22. McKimmy, Roger, MD, Oregon Medical Board Vice Chair. "The Pitfalls of Electronic Medical Records." *Oregon Medical Board Report*. Vol. 124, No. 4, Fall 2012: pp. 1, 8-9. <http://www.oregon.gov/omb/Newsletter/Fall%202012.pdf>.
23. CMS. Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services; Final Rule (42 CFR Part 410). *Federal Register* / Vol. 66, No. 226. <https://www.cms.gov/medicare/coverage/coveragegeninfo/downloads/lab1.pdf> .
24. CMS. "Definitions, Order." *Medicare Benefit Policy Manual* (Pub. 100-2). Chapter 15 – Covered Medical and Other Health Services, § 80.6.1.
25. Noridian Medicare. "Signature Requirement Questions and Answers." Updated February 2015. Last accessed January 7, 2016. <https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirement-q-a> .

26. Noridian Medicare. "Signature Requirements." Last accessed May 18, 2017. < <https://med.noridianmedicare.com/web/jeb/cert-reviews/signature-requirements>> .
27. CMS. "Signature Attestation Statement." *Medicare Program Integrity Manual*. Publication 100-08, chapter 3, § 3.3.2.4.C.
28. Noridian Medicare. "Proof of Delivery." Last accessed September 27, 2017. <https://med.noridianmedicare.com/web/jddme/topics/documentation/proof-of-delivery> .
29. Noridian Medicare. "Avoiding CERT denials for Proof of Delivery." Last accessed 8/22/2017. <https://med.noridianmedicare.com/web/jddme/avoiding-cert-denials-for-proof-of-delivery>.
30. Noridian Medicare. "Proof of Delivery - Requirements for Signature and Date." Last accessed 8/22/2017. <https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/proof-of-delivery-requirements-for-signature-and-date> .
31. American Medical Association. "How to Code from an Operative Report." *CPT Assistant*, Fall 1992, page 23.
32. American Medical Association. "Measuring & Coding the Removal of a Lesion." *CPT Assistant*, Fall 1995, page 3.
33. American Medical Association. "Coding Communication: Excision of Lesions." *CPT Assistant*, November 2002, page 5.
34. HCPro. "Learn How To Read An OP Report." *JustCoding News: Outpatient*, April 18, 2012. <http://www.hcpro.com/HIM-279024-8160/Learn-how-to-read-an-OP-report.html> . Last accessed 11/22/2017.
35. "How The Operative Report Is Used To Medically Code A Surgical Procedure." <http://www.dummies.com/careers/medical-careers/medical-billing-coding/how-the-operative-report-is-used-to-medically-code-a-surgical-procedure/> . Last accessed 11/22/2017.
36. Edwards, Brenda, CPC, CPB, CPMA, CPC-I, CEMC. "Code From The Operative Note." *AAPC Knowledge Center*. June 9, 2015. <https://www.aapc.com/blog/30884-code-from-the-operative-note/> . Last accessed 11/22/2017.

## **IMPORTANT STATEMENT**

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other

professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.

## 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)**

**Schott, Sharon. “How Poor Documentation Does Damage in the Court Room.” Journal of AHIMA 74, no. 4 (April 2003): 20-24.**

**Dougherty, Michelle. “Maintaining a Legally Sound Health Record.” Journal of AHIMA 73, no. 8 (April 2003): 64A-G.**