Administrative Policy Statement
INDIANA MARKETPLACE PLANS

Policy Name	Policy Number	Date Effective
Medical Record Documentation Standards for Practitioners	AD-0757	06/01/2020
Policy Type		
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

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A. Subject

Medical Record Documentation Standards for Practitioners

B. Background

Medical record documentation is a fundamental element required to support medical necessity and is the foundation for coding and billing. Documentation relays important information such as (but not limited to) assessments completed, services provided, coordination of services, timeliness of care, plan of treatment, rationale for orders, health risk factors, member's progress, and response to treatment.

C. Definitions

- **A Valid signature for services provided or ordered** -
  - May be handwritten or electronic;
    - CMS permits stamped signatures if you have a physical disability and can prove to a CMS contractor you are not able to sign due to that disability; and
  - Is legible or can be validated by comparing to a signature log or attestation statement.
- **Certificate of medical necessity** (CMN) - A written statement by a practitioner attesting that a particular item or service is medically necessary for an individual.

D. Policy

I. Medical documentation
   A. General requirements
      1. Each member has their own medical record.
      2. Entries are legible.
      3. Each page of the record includes the member's name and date of service.
      4. Entries include:
         a. Date of service**;** and
         b. Signature, date, and credentials of practitioner.
      5. Documentation indicates that the services(s) billed were the services provided.
         a. If CPT is based on a timed service, the total number of timed minutes and/or start and stop time with CPT codes/type of treatment is documented.
         b. If CPT is based on a group of members, the following is included:
            01. Documentation to support that the member was present at each session. If member is not present for the duration of the visit, document start and stop time for the member.
            02. Relationships/credentials of individuals present at each session.
            03. Number of participants in group therapy/treatment.
         c. CPT/Modifiers/Place of service codes are appropriate for service and provider.
         d. Note reflects the location of service.

6. Documentation reflects medical necessity for payment of services provided and utilization of resources as it relates to the service provided and the
7. needs/desires of the member.
   Documentation includes a problem list that includes significant illness or medical and behavioral conditions found in history or previous encounters.
8. When making changes in paper medical record:
   a. Change is clearly visible;
   b. White out is not utilized; and
   c. A single line is through an entry labeled with error, initialed, and dated.
9. When making changes in electronic medical records:
   a. Amendment, correction or delayed entry is identified; and
   b. A reliable way to identify the original content, the modified content, and the date and person modifying the record is provided.
10. When documentation is over multiple pages:
    a. Additional pages from a continuation of a note are clearly identified; and
    b. Continuous pages contain:
       a. Member name;
       b. Date of service; and
       c. Page number.
11. Content of documentation shows the specific needs of the member for each encounter. Duplication of another note is not acceptable.

B. Evaluation and management documentation
   1. Per CPT guidelines, documentation supports the specific requirements based on the level of visit billed.
   2. History documentation includes:
      a. Chief Complaint - reason for the visit;
      b. History of present illness (HPI);
      c. Review of systems (ROS) to identify signs and/or symptoms; and
      d. Past medical, family and social history (PFSH).
   3. Examination documentation includes:
      a. Constitutional including vital signs and general appearance; and
      b. Up to 11 organ systems/body areas depending upon the level of the examination performed and coded.
      .
   4. Complexity documentation includes:
      a. Diagnoses and treatment options;
      b. Any labs, radiology or other diagnostic tests ordered/results reviewed;
      c. Any counseling/coordination of care, which can include time spent face to face; and
      d. Medical plan of care details.

C. Consents
   1. Are maintained in the medical record.
      a. Consent includes:
         a. Consent to treatment, refusal to consent, or withdrawal of consent; and/or
         b. Authorization for release of information; and
         c. Signature and date.

D. Referral Documentation

1. Supports rationale for referral that includes who and what specialty member is referred to; and
2. Demonstrates evidence of:
   a. Coordination of referrals to specialty practitioners; and
   b. Physician review of or documentation of collaboration notes.

E. Laboratory Testing Documentation (i.e. labs, x-rays, biopsies):
   1. Documentation supports rationale for test;
   2. An order for the test is present;
   3. How test results will guide treatment plan is evident;
   4. Evidence of physician review of results; and
   5. Evidence of appropriate timely follow up on test results with member.

F. Preventative Care Documentation- when appropriate
   1. Records include:
      a. An age appropriate immunization record;
      b. Evidence that preventative screenings/services are offered;
      c. Risk assessments are completed as appropriate (i.e. Substance use, suicide, depression); and
      d. Crisis/safety plan as appropriate.

II. Durable Medical Equipment Prosthetics Orthotics and Supplies Documentation Requirements

A. Detailed Written Order and Documentation includes:
   1. The member's name;
   2. Item of DME ordered (i.e. written description, HCPCS Code, brand name, model #);
   3. Prescribing practitioner's National Provider Identifier (NPI);
   4. Signature of the ordering practitioner;
   5. Date of the order;
   6. If order is for a supply:
      a. Frequency of use.
      b. Quantity to be dispensed;
   7. Duration of use;
   8. Certificate of Medical Necessity (CMN) if required.
      a. If a CMN is not required, a prescription with diagnoses is included;
   9. Information that demonstrates that the item is medically necessary;
   10. Any changes in the member's treatment plan or needs;
   11. Proof of delivery (see II. B.);

B. Proof of Delivery
   1. Proof of Delivery includes the following:
      a. Member's name;
      b. Delivery address;
      c. Item of DME ordered (i.e. written description, HCPCS Code, brand name, model #);
      d. Quantities delivered;
      e. Date delivered;
      f. Member or designee receipt signature with date; and date of signature;
      g. Relationship of anyone signing the delivery ticket as a designee of the patient;

h. There is a specific statement for the patient to initial stating that they attest that they are satisfied with the way the orthotic or prosthesis device(s) fit and that they were trained on the proper usage and care of the device(s); and
i. Signature of the supplier and date the item was provided to the member.

2. If shipped using a third-party, shipping tracking slip or returned postage-paid delivery invoice is acceptable.
3. CareSource is able to determine from the delivery documentation that the supplier properly coded the item(s) that the item(s) delivered are the same item(s) submitted to for reimbursement, and that the items are intended for and received by a specific member.

C. Custom item documentation includes:
1. Evidence that the item was uniquely constructed or substantially modified for a specific member;
2. Description and orders of a physician;
3. Evidence that item is so different from another item for the same purpose that the two items cannot be grouped together for pricing purposes.

II. Behavioral Health Services
A. Content of documentation aligns with service (i.e. interventions, intensity)
B. Treatment plan includes all of the following:
1. Mutually agreed upon quantifiable treatment goals;
2. Target dates for goals to be met;
3. Responses to ongoing treatment; and
4. Documentation that the plan has been reviewed with the patient and, as appropriate, with family members, parents, legal guardians or custodians or significant others.

NOTE: If the member is unable or refuses to participate in the treatment planning or services, document reason given.

5. Test results, interpretation, and evidence practitioner has reviewed.
6. Evidence that member has the cognitive capacity to benefit from treatment.

C. Progress note includes all of the following as applicable:
1. Type of service;
2. Description of service;
3. Date(s) of service;
4. Time of day;
5. Duration of service;
6. Location of service;
7. Current symptoms;
8. Changes in functional impairment or symptoms;
9. Changes in medications;
10. Time spent face to face with member;
11. Time spent by practitioner interpreting and reporting on procedures as applicable;
12. Description of member progress or lack of progress; and responses to treatment.
13. Modifications in treatment plan; and

14. Evidence of clinical supervision if applicable.

D. Discharge from treatment includes all of the following:
   1. Outcomes from treatment; and
   2. Continued care linkages i.e. referrals.

E. Conditions of Coverage

F. Related Policies/Rules

G. Review/Revision History

DATES		ACTION
Date Issued	**03/04/2020**	
Date Revised		
Date Effective	06/01/2020	New policy
Date Archived	07/01/2021	

H. References

1. Centers for Medicare & Medicaid Services. (1997). *Documentation Guidelines for Evaluation and Management Services.* Retrieved February 13, 2020 from https://www.cms.gov
2. Centers for Medicare & Medicaid Services. (2015, December). *Electronic Health Records Provider.* Retrieved February 13, 2020 from https://www.cms.gov
3. Centers for Medicare & Medicaid Services. (2012, December 7). *Pub 10-08 Medicare Program Integrity Transmittal 442*. Retrieved February 13, 2020 from https://www.cms.gov
4. Centers for Medicare & Medicaid Services. (2017, August). *Evaluation and Management Services. Medicare Learning Network ICN 006764*. Retrieved February 13, 220 from https://www.cms.gov
5. Centers for Medicare & Medicaid Services. (2018, May). *Complying with Medicare Signature Requirements Medicare Learning Network ICN 905364*. Retrieved February 13, 2020 from https://www.cms.gov
6. Centers for Medicare & Medicaid Services. (2020, January 1). *Local Determination Article: Standard Documentation Requirement for All Claims Submitted to DME MACs (A55426).* Retrieved February 13, 2020 from https://www.cms.gov
7. United States Code of Regulations. (2019, November 8). *§ 410.38 Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS): Scope and conditions.* Retrieved February 13, 2020 from https://ecfr.io
8. United States Code of Regulations. (1993, June 30). *§414.224 Customized items.* Retrieved February 13, 2020 from https://ecfr.io

The Administrative Policy Statement detailed above has received due consideration as defined in the Administrative Policy Statement Policy and is approved.