ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Medical Record Documentation Standards for Practitioners- GA MCD-AD-0755	09/01/2025-07/31/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates 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 CareSource and its affiliates 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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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.
  - 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 and include
a. date of service
b. signature, date, and credentials of practitioner
3. Each page of the record includes the member's name and date of service.
4. 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.

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5. Documentation reflects medical necessity for payment of services provided and utilization of resources as it relates to the service provided and the needs/desires of the member.
6. Documentation includes a problem list that includes significant illness or medical and behavioral conditions found in history or previous encounters.
7. When making changes in paper medical record
   a. Change is clearly visible.
   b. White out is not utilized.
   c. A single line is through an entry labeled with error, initialed, and dated.
8. When making changes in electronic medical records
   a. Amendment, correction or delayed entry is identified.
   b. A reliable way to identify the original content, the modified content, and the date and person modifying the record is provided.
9. When documentation is over multiple pages
   a. Additional pages from a continuation of a note are clearly identified.
   b. Continuous pages contain
      01. member name
      02. date of service
      03. page number
10. Content of documentation shows the specific needs of the member for each encounter. Duplication of another note is not acceptable.
11. Best practice standards require documentation to be written within 24 hours of the clinical or therapeutic activity and signed and dated within 14 days.

B. Evaluation and management documentation
   1. Per CPT guidelines, documentation supports the specific requirements based on the level of service billed. These include
      a. time
      b. medical decision making
      c. complexity
   2. Complexity documentation may include
      a. self-limited or minor problems
      b. stable chronic
      c. acute, uncomplicated illness or injury
      d. undiagnosed new problem with uncertain prognosis
      e. chronic illnesses with severe exacerbation, progression, or side effects of treatment
   3. Risks associated with social determinants of health (SDOH) are documented, if applicable.

C. Consents
   1. Are maintained in the medical record.
      a. Consent includes
         01. consent to treatment, refusal to consent, or withdrawal of consent
         02. authorization for release of information.
         03. signature and date

D. Referral Documentation

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

E. Laboratory Testing Documentation (ie, 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. Physician review of results is evident.
5. Evidence of appropriate timely follow up on test results with member.

F. Preventative Care Documentation, when appropriate include
1. age appropriate immunization record
2. evidence that preventative screenings/services are offered
3. risk assessments are completed as appropriate (ie, substance use, suicide, depression)
4. crisis/safety plan as appropriate

II. Durable Medical Equipment Prosthetics Orthotics and Supplies Documentation Requirements

A. Detailed Written Order and Documentation includes
1. member's name
2. item of DME ordered (ie, written description, HCPCS code, brand name, model number)
3. prescribing practitioner's National Provider Identifier (NPI)
4. signature of the ordering practitioner
5. date of the order
6. order 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 demonstrating medical necessity
10. any changes in the member's treatment plan or needs
11. proof of delivery (see II. D.)

B. Refill Documentation
1. Documentation of a request for refill must be either a written document received from the member or a contemporaneous written record of a phone conversation/contact between the supplier and the member.
2. The refill request must occur and be documented before shipment.
3. A retrospective attestation statement by the supplier or member is not sufficient.
4. The refill record must include:

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a. Member's name or authorized representative, if different from the member.
b. A description of each item that is being requested.
c. Date of the refill request.
d. For consumable supplies ie, those that are used up (eg, ostomy or urological supplies, surgical dressings) the supplier must assess the quantity of each item that the member still has remaining to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.

C. Verbal Orders
1. When services are provided based on a physician's verbal orders, a nurse or other qualified practitioner responsible for furnishing or supervising the ordered services, must document the orders in the patient's clinical record, and sign, date, and time the orders.
2. Verbal orders must be followed up with written orders.
3. Suppliers must maintain the written physician's order to support medical necessity in the event of a post-payment review.

D. Proof of Delivery
1. Proof of Delivery includes the following:
a. member's name
b. delivery address
c. item of DME ordered (ie, written description, HCPCS code, brand name, model number)
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. 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)
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 were the same item(s) submitted to for reimbursement, and that the items were intended for and received by a specific member.

E. 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.

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III. Falsified Documentation

A. Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include
   1. creation of new records when records are requested
   2. back-dating entries
   3. post-dated entries
   4. writing over
   5. adding to existing documentation (except where described in amendments, late entries, or corrections)

B. 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.

C. 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.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Behavioral Health Record Documentation Standards for Practitioners

G. Review/Revision History

DATES		ACTION
Date Issued	03/04/2020	
Date Revised	04/14/2021	Removed BH Documentation. Updated references.
	04/13/2022	No changes; Updated references
	05/25/2022	Per SIU added Refill Documentation and Verbal Orders to section II
	05/24/2023	Added sec.I.A.12 for completion and signature. Updated references, Approved at Committee.
	01/17/2024	Updated references, Approved at Committee
	05/22/2024	Per 2024 CMS, Added complexity requirements. Updated references. Policy approved at Committee
	05/07/2025	Updated references; Policy approved at Committee
Date Effective	09/01/2025	
Date Archived	07/31/2026	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

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H. References

1. Chart records. Policies and Procedures for Physician Services. Georgia Dept of Community Health. Accessed April 11, 2025. www.mmis.georgia.gov
2. Customized Items, 42 C.F.R. § 414.224 (2023).
3. *Documentation Guidelines for Evaluation and Management Services.* Centers for Medicare & Medicaid Services; 1997. Accessed April 11, 2025. www.cms.gov
4. Documentation Matters Toolkit. Centers for Medicare & Medicaid Services. July 15, 2020. Accessed April 11, 2025. www.cms.gov
5. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS): Scope and Conditions, 42 C.F.R. § 410.38 (2023).
6. *Electronic Health Records Provider.* Centers for Medicare & Medicaid Services; 2015. Accessed April 2, 2025. www.cms.gov
7. *Evaluation and Management Services. Medicare Learning Network ICN 006764*. Centers for Medicare & Medicaid Services; 2017. Accessed April 11, 2025. www.cms.gov
8. *Guidelines for medical record documentation*. NCQA. Accessed April 11, 2025. www.ncqa.org
9. *Pub 10-08 Medicare Program Integrity Transmittal 442.* Centers for Medicare & Medicaid Services; 2012. Accessed April 11, 2025. www.cms.gov

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