Network Notification

Date: April 12, 2011 **Number: OH-P-2011-17**
MI-P-2011-09

To: Ohio and Michigan Providers

From: CareSource

Subject: Clinical Supporting Documentation Policy

This policy outlines CareSource's requirements for acceptable supporting medical record documentation used to determine reimbursement.

Accurate, complete, accessible and comprehensible medical record documentation is crucial in providing patients with quality care and in determining proper claims reimbursement.

CareSource has an obligation to require reasonable documentation to validate the site of service, the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided and that the services provided have been accurately recorded.

The principles of medical record documentation are applicable to all types of medical and surgical services in all settings, for example, chart notes, operative notes, etc.

When Submitting Documentation (Paper-based and Electronic Records):

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
   a. Name, address and date of birth
   b. Date of each visit
   c. Presenting symptoms, condition and diagnosis
   d. Pertinent patient history, progress notes and consultation reports
   e. Results of examination(s)
   f. Prior diagnostic test results not previously documented
   g. Records of assistive devices or appliances, therapies, tests and treatments which are prescribed, ordered or rendered

h. A description of observations made by the clinical provider
i. Orders for diagnostic tests including labs
j. Written interpretations of tests including documentation that the patient was notified of the results
k. Records of medication prescribed including strength, dosage and quantity
l. Patient responses to or outcomes from prescribed medications
m. Patient-centered plan of care
n. Legible name and signature of prescribing and/or referring physician
An acceptable full signature (no initials) would be either hand written or electronic. Per CMS transmittal 248, stamped signatures <u>will not</u> be accepted.

3. Pathology and Laboratory providers must provide the ordering physician's documentation.

<u>Unlisted Codes</u>

Claims that are billed with unlisted CPT codes always require a signed copy of the chart notes, medical record, operative reports in order to determine what procedure was performed on the patient. Providers may choose to submit a letter of justification along with the signed copy of chart notes, medical record, operative notes to clarify the use of any unlisted CPT codes.

Claims that are billed with unlisted HCPCS codes always require a signed copy of the chart notes/medical records or a manufacturer's invoice to determine what service or DME item was provided to the patient.

<u>Appeals</u>

Any time a claim is appealed, the provider must submit supporting signed documentation, such as chart notes, operative report, radiology reports, and history and physical.

<u>Modifiers</u>

Based on the modifier billed, the appropriate signed documentation (chart notes, medical records or **op notes**) should be submitted with the claim. The documentation must support the usage of the modifier in question.

Table Key	
CH – chart notes/med records	**OP –** op notes

Modifiers			
• 22 – OP	• 24 - CH	• 25 - CH	• 57 - CH
• 58 – OP	• 59 - OP	• 62 - OP	• 77 – OP/CH
• 78 – OP/CH	• 79 – OP/CH	• 80 - OP	• 82 - OP

CareSource applies the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services to all medical record documentation reviews.

CareSource's General Principles are offered as reference information only and are not intended to serve as legal advice. CareSource recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.