Network Notification

Date: August 5, 2015

To: Kentucky Physicians

From: Humana – CareSource®

Subject: Revised Clinical Supporting Documentation Policy

Please note the following Humana – CareSource requirements for acceptable supporting medical record documentation used to determine reimbursement:

- Humana – 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 were accurately recorded.
- These standards are designed to ensure that all physicians are responsible for the maintenance and integrity of all medical documentation.
- Traditional paper format or electronic format records documentation should follow the steps outlined below to ensure the credibility of the medical record:
  1. The medical record should be complete and legible.
  2. The documentation of each patient encounter should include:
     a. Name, address and birth date.
     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 that 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. Physician's signature (see requirements below).
- In accordance with Centers for Medicaid & Medicare Services (CMS) requirements, valid signature and/or acceptable methods of signing medical record documentation are as follows:
  1. Handwritten (paper):
     a. Legible name and signature of prescribing and/or referring physician.
     b. Per CMS transmittal 248, stamped signatures will not be accepted.

2. Electronic medical record (EMR): Usually contains date, timestamps and printed statements. For example:
    a. “Signed before import by” with provider’s name.
    b. “Signed: John Smith, M.D.” with provider’s name.
    c. “This is an electronically verified report by John Smith, M.D.”
    d. “Authenticated by John Smith, M.D.”
    e. “Authorized by: John Smith, M.D.”
    f. “Digital signature: John Smith, M.D.”
    g. “Confirmed by” with provider’s name.
    h. “Closed by” with provider’s name.
    i. “Finalized by” with provider’s name.
    j. “Electronically approved by” with provider’s name.
    k. “Signature derived from controlled access password.”
    l. “Signature on file.”
3. Digitized: An electronic image of an individual’s handwritten signature reproduced in its identical form.
4. Initials: Permitted as long as the physician’s name appears in printed form somewhere on the medical record documentation.
    a. Please note: Physicians may include in the submitted documentation a signature log that lists the typed or printed name of the author associated with the initials or an illegible signature. Physicians also may include in the documentation an attestation statement. In order to be considered valid for medical review purposes, the attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Additional information:
Pathology and laboratory providers must provide the ordering physician’s documentation.

- Unlisted codes:
  Claims that are billed with unlisted Current Procedural Terminology (CPT) codes always require a signed copy of the chart notes/medical record/operative notes in order to determine what procedure was actually 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 unlisted CPT codes.

  Claims that are billed with unlisted Healthcare Common Procedure Coding System (HCPCS) codes always require a signed copy of the chart notes/medical records or a manufacturer’s invoice to determine what service or durable medical equipment (DME) item was provided to the patient.

- Appeals:
  When a claim is appealed, the provider must submit signed supporting documentation such as chart notes, operative reports, radiology reports, history and physical.

- Modifiers:
  Based on the modifier billed, the appropriate signed documentation (e.g., chart notes/medical records or operative notes) should be submitted with the claim. The documentation must support the usage of the modifier in question.

Table Key	
CH – chart notes/medical records	**OP –** operative 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

Humana – CareSource applies the guidelines outlined in the 1995 and 1997 versions of "Documentation Guidelines for Evaluation and Management Services" to all medical record documentation reviews.

The principles of medical record documentation are applicable to all types of medical and surgical services in all settings (e.g., chart notes, operative reports, etc.).

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