Network Notification

Date: May 6, 2015

To: Ohio Health Partners

From: CareSource®

Subject: Revised Clinical Supporting Documentation Policy

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

These standards are designed to ensure that all providers are responsible for the maintenance and integrity of all medical documentation. 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 (e.g. chart notes, operative reports, etc). Regardless of whether the medical record is in the traditional paper format or electronic format, these steps should be taken to ensure the credibility of the medical record.

- The medical record should be complete and legible
- 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 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. Provider signature (see requirements below)

In accordance with CMS requirements, a valid signature and/or acceptable method of signing medical record documentation is as follows:

Paper:

- Handwritten
  a. Legible name and signature of prescribing and/or referring physician
  b. Per CMS transmittal 248, stamped signatures will not be accepted

EMR – Electronic:

- Electronic: 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”

Please note, this section is new

- Digitized: An electronic image of an individual’s handwritten signature reproduced in its identical form.
- Initials: Permitted as long as the provider’s name appears in printed form somewhere on the medical record documentation.
  - Note: Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature. Providers may also 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 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 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.

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

- Modifiers:
  Based on the modifier billed, the appropriate signed documentation (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/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.