

Coding Policy

Documentation Guidelines for Medical Services

CODING POLICY NUMBER: 58

Effective Date: 10/1/2026

Last Review Date: 9/2026

Next Annual Review: 2027

POLICY STATEMENT.....	1
PROCEDURE	2
REFERENCES.....	5
POLICY REVISION HISTORY.....	5

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”). **The full Company portfolio of current coding policies is available online and can be [accessed here](#).**

POLICY APPLICATION

- | | |
|--|---|
| ☒ Providence Health Plan Participating Providers | ☒ Non-Participating Practitioners |
| ☒ Commercial | ☒ Medicaid/Oregon Health Plan |
| | ☒ Medicare |

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY STATEMENT

- I. Medical records are required to be complete, legible, and clearly support the services billed.
- II. Company may review any claim-related information, including medical records. Upon request, providers must submit all required documentation by the deadline stated in the

written notice. Insufficient, incomplete, or missing records will result in the service or item being deemed undocumented, therefore not eligible for payment.

- III. Providers must adhere to documentation standards established by recognized regulatory and accrediting bodies, including but not limited to, CMS, The Joint Commission, AMA, and NCQA, as well as all applicable state and federal regulations such as the Health Insurance Portability and Accountability Act (HIPAA). This policy does not address all possible documentation requirements or circumstances.

PROCEDURE

COMPLETE MEDICAL RECORDS

Medical records must be complete, legible, and accurately reflect the patient's condition and care provided. For each encounter, the documentation should clearly identify the patient, date of service, chief complaint or reason for the visit, and include the pertinent history, physical examination, findings, or diagnostic results as appropriate. It should also provide an assessment and impression, or final diagnosis, and outline the plan of care. Each entry must include legible provider identification and authentication.

Providers are responsible for documenting services in the appropriate office or hospital record at the time they are delivered, including sufficient detail to support diagnostic tests, procedures, and the billed level of care. Vague or ambiguous documentation, such as "same as above" or the use of ditto marks, are not acceptable.

In addition to physician notes, a complete medical record may also contain:

- Provider orders
- Patient questionnaires related to services
- Progress notes from other providers when directly referenced in the current note
- Treatment logs
- Professional consultation reports
- Procedure, lab, x-ray, and other diagnostic reports

All services and supplies billed must be fully supported by documentation in the patient's record, and these records must be available for review upon request.

Surgical Procedures

The operative report must contain complete documentation of the procedure performed, including the following:

- Date and time of the procedure
- Pre- and postoperative diagnoses
- All procedures performed
- Type of anesthesia
- Names, roles, and credentials of all participating providers (e.g., surgeon, co-surgeon, assistant, resident)
- Summary of findings, including size of tumors or lesions, complications, extra work involved in the procedure, or other key information.
- **Detailed procedural description**, including patient positioning, surgical approach, structures treated, and specific actions taken (e.g., suturing, debridement, grafting)
- Signatures of all contributors, with clear identification of the author for each part of the record.

Radiology Reports

When billing the professional component of a diagnostic study (e.g. X-ray, CT, MRI), the interpreting physician must generate an official interpretation and report. A mere review and summary of images or findings without a complete written report does not meet requirements for separate payment.

Required Elements:

- Demographics:
 - Patient name
 - Interpreting provider name
 - Referring provider name
 - Date and time of study
- Clinical information:
 - Relevant clinical information
 - Diagnosis or reason for study
- Technique:
 - Procedure performed
 - Extent of exam (e.g. limited, complete)
 - **Number of views**
 - **Anatomical site (including laterality when appropriate)**
 - Contrast media or radiopharmaceuticals (concentration, volume, route), if applicable
 - Catheters, devices, or other materials used, if applicable
 - Significant patient reaction or complications, if applicable
- Findings
 - Detailed description of relevant anatomy, abnormalities, or variations
 - Comparison to prior studies, if available
- Impression
 - Definitive diagnosis or differential diagnoses after study
 - Clinical relevance of findings as appropriate
 - Recommendation for follow-up studies or consultations, if applicable
- Authentication
 - Date the report was finalized
 - Interpreting provider's signature

Laboratory Tests

Laboratory tests must be ordered by a physician or other qualified healthcare provider (i.e. NP, PA) to be eligible for payment. An order is considered valid if any of the following are present:

- A signed order or requisition listing the specific test(s); or
- An unsigned order or requisition listing the specific test(s) AND an authenticated medical record that supports the provider's intent to order (e.g., "order labs," "check blood," "repeat urine"); or
- An authenticated medical record entry that both documents the provider's intent to order and lists the specific test(s).

If an order is communicated by telephone, both the treating provider and the testing facility must document the call in their respective medical records.

SIGNATURES

Company follows all applicable state and federal requirements for provider signatures on medical records, including those outlined by CMS.

All services provided and/or ordered must be authenticated by the authoring provider via a handwritten or valid electronic signature. A stamped signature is acceptable only if the author has a physical disability that prevents a handwritten signature. "Signed but not read" is not acceptable.

If signature requirements are not met, the documentation will not be considered during Company review and may result in denial for the associated services.

Author of Note No Longer with Provider Group

If the author of a medical note leaves the provider group without signing the note, the following steps apply:

- The provider group must make every reasonable effort to contact the original author and obtain an attestation statement.
- If an attestation cannot be obtained, the related bill will be removed or refunded.

COPIED OR "CLONED" MEDICAL RECORDS

Documentation for Evaluation and Management (E/M) services must support the time or medical decision making for the level of service billed. The medical record for each E/M service should clearly reflect the services provided on that specific date.

Information that is copied from a previous date or prepopulated template must be clearly identified as cloned or copied, for example by adding the current date to the new or updated information. Only

information that is new or reviewed and updated by the provider on the date of service may be used to determine the level of service billed.

LATE ENTRY, ADDENDUM, OR CORRECTIONS

A **late entry** supplies information that was omitted from the original entry but should have been included at the time of service. It must be added as soon as possible, include the current date, and be documented only if the author has complete recall of the omitted details.

Example: *"The left foot was noted to be abraded laterally."*

An **addendum** supplies new or clarifying information that was not available at the time of the original entry. It must also be timely and include the current date and reason.

Example: *"The chest x-ray report was reviewed and showed an enlarged cardiac silhouette."*

A **correction** is made to revise an error in the medical record. It must never obscure the original entry; the medical record must clearly show both the original entry and the correction, including the current date, time, reason, and identity of the person making it.

Falsified Documentation

Deliberate falsification of medical records is a felony and will be addressed with the utmost seriousness. Examples of falsifying records include:

- Creating new records in response to a records request
- Back-dating, post-dating, or pre-dating entries
- Writing over existing entries
- Adding to existing documentation, except as allowed for late entries, addendums, or corrections

Corrections legally made to the medical record *before* claims submission, medical review, and/or coding audit will be considered when determining the validity of billed services. If changes appear *after* payment determination, only the original record will be used to determine payment.

Claims denied due to an incomplete record may be overturned on appeal if the additional information provided was part of the original medical record but not included in the initial submission.

REFERENCES

1. CMS/Medicare Rules and Regulations (cms.gov)
2. American Medical Association. Current Procedural Terminology (CPT)
3. Providence Health Plan Clinical Coding Edits

POLICY REVISION HISTORY

Date	Revision Summary
3/2004	Original policy effective date.
3/2023	Annual review. Converted to new template 5/2023.
8/2023	Updated to show PHP follows all State and federal HIPAA requirements for signatures on medical records.
1/2024	Annual review. No changes.
4/2024	Removed HIPAA language from the policy. PHP follows state and federal HIPAA requirements for signatures. Providers need to refer to those guidelines for information.
1/2025	Added reference to Coding Policies 67.0.A, 67.0.E, and 92.0 for information about E/M codes 90800-90816.
9/2025	Added bullet III to Policy statement. Removed E/M information. Moved therapy details to CP 85.0. Incorporated Late Entry, Addendum or Correction information from archived CP 60. Applied formatting updates and edited content for brevity and clarity.