

<b>Coding Policy Policy and Procedure</b>		
SUBJECT: Coding Policy 58.0 Documentation Guidelines for Medical Services	DEPARTMENT: <b>Health Care Services</b>	
ORIGINAL EFFECTIVE DATE: 03/2004	DATE(S) REVIEWED/REVISED: 01/05-01/16, 01/17, 01/18, 01/19, 08/19, 11/19, 01/20, 01/21, 01/22, 01/23	
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**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”).

**APPLIES TO:**

Health Plan Providers  
All Lines of Business

**POLICY:**

Medical records are required to be complete and legible and include the reason for the encounter, relevant history, condition-specific physical exam, diagnostic findings, and test results. The documentation must include an assessment and impression or diagnosis, a plan of care, the date of service, and legible identity of the provider. The records should not only substantiate the service performed but also the level of care required. The patient’s progress, response to and changes in treatment, and revisions of diagnosis(es) should be included in the documentation.

Company may review any information, including medical records, pertaining to a claim.

**PROCEDURE:**

**1. Elements of a Complete Medical Record May Include:**

- Provider orders, and/or certifications of medical necessity
- Patient questionnaires associated with provider services
- Progress notes of another provider that are referenced in the provider’s note
- Treatment logs
- Related professional consultation reports
- Procedure, lab, x-ray and diagnostic reports

**2. Providers Billing Company for Services Must:**

- Document in appropriate office and/or hospital records each time a service is provided.
- Identify the provider's specialty if more than one provider performs services.
- Write medical information legibly and sign each entry with a legible valid signature. The medical information should be clear, concise and reflect the patient's condition. (See instructions for signatures below.)
- Sign progress notes for hospital and custodial care facility patients. All entries should be dated and signed by the provider who actually examined the patient.
- Provide sufficient detail to support diagnostic tests that were furnished and the provider's level of care billed.
- Provide rationale for separate procedures or services performed for purposes other than treating the chief complaint.
- Not use statements such as "same as above" or ditto marks. These are not acceptable documentation that the service was provided for that date.

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### 3. Documentation Requirements for Office Evaluation and Management (E/M) Services:

Company follows CMS guidelines for use of office/other outpatient E/M codes (99202-99205 and 99211-99215), including, but not limited to, the guidelines in this section.

- The level of E/M service billed may be determined by time alone OR by medical decision making. **Only time spent by the billing practitioner may be used to determine the level of service. Time spent by office staff may not be used to determine the level of service.**
- Time used to support the level of service may be both face-to-face and non-face-to-face time, **but only the billing practitioner’s time may be considered.**
- When selecting an E/M code level based on time, the number of minutes specified in the descriptor for the relevant CPT code must be **met or exceeded.**
- **Company does not recognize CPT codes 99415, 99416, 99417, 99418, 99358, or 99359 for prolonged services.**
- HCPCS codes G2212, G0316, G0317, and G0318 may be used to report prolonged services in 15-minute increments beyond the maximum time listed in the time range for the highest level of service in each E/M category for which the code is used. (See Coding Policy 52.0 “Medical Visits” for details.) HCPCS codes G2212, G0316, G0317, and G0318 may be used only for a full 15-minute block of time, not for less than 15 minutes.
- CPT code 99211 may be used when the health care professional’s time is spent in supervision of clinical staff who perform face-to-face services.

When selecting an E/M code which includes a time range in the description, the clinician may use either the new medical decision-making definitions or total time spent on that date of service.

Use only clinician time, not staff member time, when using time to select the appropriate E/M code or add-on prolonged care code. The nature of the work must require practitioner knowledge and expertise. **Time spent by the practitioner must be documented in the chart with a description of how the time was spent. The clinician’s documentation must support all acute and/or chronic conditions addressed.**

### 5. Documentation Requirements for 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.
- A list of all procedures performed.
- Type of anesthesia used.
- All surgeons who participated in the case and the role of each. This includes resident providers, co-surgeons, and assistant surgeons and/or NP’s or PA’s who assisted in the case.
- Indications for the procedure.

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- A summary of findings, including the size of tumors or lesions, complications, extra work involved in the procedure, and other key information.
- **Detailed description of the procedure, including the patient’s position, the approach or approaches used, and the specific organ, structure, or area being treated, and a detailed description of the work performed. For example, it is not appropriate to say, “arthrodesis was performed.” The work involved to complete the arthrodesis must be documented in detail. Documentation should include information about vessels or ligaments or other supporting structures that were cut or sutured, removal of organs or other structures or loose or foreign bodies, areas that were debrided, grafts or transplants, including description of material grafted or transplanted, etc.**
- Signatures of everyone who documented any part of the operative note. It should be possible to identify who documented each element of the note and, if any changes or amendments were made, who made them and when.

**6. Documentation Requirements for Therapy Services (See also Coding Policy 85.0):**

Documentation for all therapy visits, including (but not limited to) occupational therapy, physical therapy, speech therapy, rehabilitation therapy, must include the following elements:

- Date of visit
- Identification of each specific intervention/modality provided
- Total visit time
  - This includes all time spent providing direct services to the patient, for both untimed and time-based codes. Time spent during rest periods or waiting for equipment should not be counted in the total minutes.
- Total time-based code only minutes
  - This includes the total minutes providing only time-based code services. The amount of time for each specific intervention/modality must be recorded, as well as the total time for all time-based codes. Time spent during rest periods or waiting for equipment should not be counted in the total minutes.
- Legible signature and professional identification of the provider of service

**7. Documentation Requirements for Radiology Reports:**

An official interpretation (final report) by the interpreting physician must be generated when billing the professional component of any diagnostic study, such as x-rays. This “interpretation and report” is different from the “review” of a study. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service.

REQUIRED components of all Radiology reports:

- A. Demographic information:
- Patient name

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- Provider name
- Referring provider
- Name/type of examination
- Date and time of examination
- B. Clinical information:
  - Relevant clinical information
  - Diagnosis
- C. Body of report:
  - Procedure performed
  - ❖ **Number of views REQUIRED for all Radiology reports**
  - ❖ **Anatomical site (including notation of left or right side when appropriate) REQUIRED for all Radiology reports**
  - Description of study
  - Materials used, including amounts and types of medications, if applicable
  - Significant patient reaction if applicable
  - Findings
  - Clinical issues if applicable
  - Comparison studies if available
- D. Impression
  - A precise diagnosis and/or differential diagnosis
  - Follow-up studies recommended if applicable

### **8. Documentation Requirements for Laboratory Tests:**

Medically necessary and reasonable laboratory tests are paid only if ordered by the physician who is treating the patient. Tests not ordered by the treating physician are not reasonable and necessary and therefore are not covered. Company does not require the physician's signature on orders for a laboratory test as long as the physician clearly documents in the medical record his or her intent that the test be performed. Requirements for diagnostic laboratory test orders are met if there is:

- A signed order or signed requisition listing the specific test; or
- An unsigned order or unsigned laboratory requisition listing the specific tests to be performed AND an authenticated medical record that supports the physician's or practitioner's intent to order the tests (e.g., "order labs," "check blood," "repeat urine"); or
- An authenticated medical record that supports the physician's or practitioner's intent to order the specific tests. In this case, the specific tests to be ordered must be listed in the record.

If the order is communicated by telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the patient's medical records.

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### 9. Instructions for Signatures:

**Services provided/ordered must be authenticated by the author. The required method is a handwritten or electronic signature.** A stamped signature is not acceptable unless the author has a physical disability that prevents a handwritten signature. Documentation submitted in response to Company's request for records should comply with these requirements. It is the provider's responsibility to contact the hospital or other facility where the service was provided to obtain the required signed notes or orders if Company requests these records.

If the provider questions the legibility, timeliness, validity, or presence of his or her signature, an attestation may be submitted with the records.

**If signature requirements are not met, i.e., signature is tardy, missing, or illegible, the documentation will not be considered when a review is conducted by Company. This may result in a determination by Company that medical necessity for the service has not been substantiated.**

- Definition of a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.

An electronic signature will be acceptable if it is added to statements such as "authenticated by" or "reviewed by." It must be clear to the reviewer that this is an electronically generated statement. A typed name alone is not valid and would need to have a handwritten signature authenticating the entry. Examples of acceptable electronic signatures include, but are not limited to:

- Chart "Accepted By" with provider's name
- "Electronically signed by" with provider's name
- "Verified by" with provider's name
- "Reviewed by" with provider's name
- "Released by" with provider's name
- "Signed by" with provider's name
- "Signed before import by" with provider's name
- "Signed" with provider's name
- Digitalized signature, handwritten and scanned into the computer
- "This is an electronically verified report by" with the provider's name
- "Authenticated by" with the provider's name
- "Authorized by" with the provider's name
- "Digital Signature:" with the provider's name
- "Confirmed by" with the provider's name
- "Closed by" with the provider's name
- "Finalized by" with the provider's name

**Note: "Signed but not read" is not acceptable**

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**Providers should not add late signatures to the medical record, beyond the short delay that occurs during the transcription process. If a record is unsigned, a late signature will not be accepted, and services will not be eligible for reimbursement.**

If the entry to a record lacks a signature or the signature is found to be illegible, the provider may:  
**Submit a Signature Log for illegible signatures**

Definition: A signature log identifies the author associated with initials or an illegible signature. The log must be part of the patient’s medical record. Providers may include a signature log with documentation submitted to Company.

**Submit an Attestation Statement for missing, invalid, or tardy signatures**

- In order to be considered valid for review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement: “I, \_\_\_\_\_[print full name of the provider/practitioner]\_\_\_\_, hereby attest that the medical record entry for \_\_\_\_\_[date of service]\_\_\_\_ accurately reflects signatures/notations that I made in my capacity as \_\_\_\_\_[insert provider credentials, e.g., M.D.]\_\_\_\_when I treated/diagnosed [insert name of patient here, or if added to the end of chart note refer to patient listed above]. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”

**Reviewers will NOT consider attestation statements from someone other than the author of the medical record entry in question.** Even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements. An attestation statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.

**Author of Note No Longer With Provider Group**

If the author of a medical note is no longer with the provider group and has left the group without signing a note, the following steps should be taken:

- The provider group will make every attempt to contact the original author of the record to review and obtain an attestation statement as described above **bearing the current date**, noting clearly that the signature was added late and why.
- If the provider is unable to provide an attestation statement, the bill will be removed and/or, if necessary, refunded.

The burden of proof is placed on the provider to substantiate services and/or supplies billed to Company.

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During the audit process, if documentation is needed, the provider or supplier must send the beneficiary's medical record by the deadlines given in the written request.

### **Scribes**

If the physician/practitioner uses a scribe (an individual taking notes), it is not necessary for the scribe to sign the note. Only the physician/practitioner needs to sign the note.

### **Nurses' Notes**

No signature is required on a nurse's note as long as there is a separate note signed by the physician/practitioner that corroborates the information in the nurse's note.

### **10. Copied or "Cloned" Medical Records:**

Documentation for Evaluation and Management (E/M) services must support the medical necessity for the level of service billed. The medical record for each E/M service should clearly show services provided on that date. Information that is forwarded from a previous date of service, or information that is contained in a template (such as templates with pre-populated examination results), must be clearly identified as cloned or copied information. Identifying cloned or copied information in notes may be accomplished by adding the current date to information that is new for that date.

Cloned or copied information may be used to determine the level of service only if there is an indication in the note that the provider of service reviewed and updated the copied information on that date of service. Only information that is new on the current date of service or has been reviewed and updated by the provider on the current date of service may be used to determine the level of service billed. The history and examination documented must be medically necessary and appropriate based on the patient's diagnosis(es) and the interval between visits. For example, a comprehensive history and comprehensive examination of all body systems and body areas may not be medically necessary for a patient who is seen every month for trigger point injections.

When Company identifies records with identical information on multiple dates of service without any indication that the provider has reviewed or updated the copied information, only information that is new for the date in question will be allowed when determining the level of service.

### **REFERENCE:**

CMS Rules and Regulations  
Current Procedural Terminology (CPT)  
Providence Health Plan Clinical Coding Edits