MEDICAL RECORD DOCUMENTATION

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Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

The medical record is a confidential document that describes the medical care given to a patient/subscriber. The documentation is necessary to record applicable subjective and objective observations and findings regarding the patient's history, examinations, diagnostic tests and procedures, treatments and treatment plans, necessary follow-up care, diagnosis, outcomes and/or responses to care. The medical record serves as a formal document and communication between providers, patients, and insurance companies.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Benefits are payable for services provided to patients according to the terms, limitations, and exclusions of the subscriber/member contract. All services reported must be supported in the medical record.

Incomplete or illegible records can result in denial of payment for services billed to Select Health. Claim payment decisions that result from a medical review of your records are not a reflection on your competence as a healthcare professional or the quality of care you provide to your patients. Specifically, the results are based on review of the documentation received.

For a claim to be valid, there must be sufficient documentation in the member's medical record to verify the service was performed, and the appropriate level of care that was delivered. Reimbursement will not be made for services reported that are not clearly documented in the patient record.

If there is no documentation, then there is no justification for the services or level of care billed. In addition, if there is insufficient documentation on claims that have already been adjudicated by Select Health, reimbursement may be considered as an overpayment, and the funds can be partially or fully recovered.

- This coding and reimbursement policy should be considered a guideline for medical record documentation. However, for the consideration of any level of service or CPT code, medical necessity should be the ultimate guiding factor. If a service is not reasonable and necessary, Select Health will not be held liable for reimbursement for any level of coding documentation submitted may support.

Select Health Medical Records Documentation Standards

Documentation should support the intensity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision making. The CPT, HCPCS, ICD-10-CM,

DRG, APC, or Revenue Code reported on billing forms (paper or electronic) should reflect the documentation in the medical record. If a "not otherwise classified" service/procedure code is reported, a detailed description of the service/procedure performed should be clearly identified. Since these claims must be clinically reviewed, it would be helpful if the specific reference to this service/procedure were highlighted in the copy of the medical report submitted for review.

- All pertinent documentation must be maintained in the patient's medical record and be made available to SelectHealth upon request;
- Each billable encounter (procedure or service) should be a stand-alone document organized in a consistent manner;
- Any authorized individual who obtains clinical information (e.g., patient history, telephone calls, prescription refill calls, etc.) or provides clinical care can document the encounter in the patient's medical record;
- Each page of the patient's medical record should contain the patient's legal name, the licensed health care provider's name, and the date of service;
- All entries should be complete and legibly written, legibly signed, and/or initialed by the person making the entry;
- Telephone or verbal conversations concerning a patient's clinical care or medical advice should be documented and filed in the patient's medical record, and should include the date and time of the conversation;
- Telephone orders should be documented in the patient record and should be authenticated (e.g., signature or initial) by the ordering clinician;
- The start and end times or total time involved in providing the service/procedure should be documented, if time is a factor in reporting care rendered;
- All documents must be signed by a physician or an appropriate billing clinician, or a clinician responsible for supervision;
- Electronic documents must be authenticated and signed in the appropriate manner, as defined by the system used; and
    - Authentication and/or signatures may be provided as hard copies or electronically.

Electronic Medical Records/Electronic Health Records

Physician documentation including tools such as templates and "copy/paste" functions are not discouraged if the outcome is a concise, effectively communicated, medically relevant chart note. However, indiscriminate use of the copy functionality can damage the clinical trustworthiness and integrity of the medical record.

- When using a copy/paste type function or template the following must be adhered to:

    - If a history is copied from a previous record or date of service, the physician or APC must document that they reviewed it and make appropriate updates.
    - When relevant information is already contained in the medical record, clinicians can focus their documentation on what has changed since the last visit rather than having to redocument information. (Centers for Medicare & Medicaid Services [CMS], 2024)
    - For both new and established E/M office visits, a Chief Complaint or other historical information already entered into the record by ancillary staff or by patients themselves, may simply be reviewed and verified rather than reentered.
    - Documentation previously included by a resident or other member of the medical team for E/M visits need not be redocumented.

    - Only the physician or APC that bills for the service may document the history of present illness (HPI), Exam, and Medical Decision-Making portions of the progress note. These portions cannot be "identical notes" from previous visits and must pertain to the presenting problem. There should be enough changes/updates to the note to help show the service documented was performed on that date. (Prior to 1/1/2021)

- Evaluation and management services include a medically appropriate history and exam. The extent of the history and exam are determined by the treating physician or APC. The care team may collect information from the patient and/or caregivers. The information is then reviewed by the reporting physician or APC. The extent of history and exam is not an element for selection of the outpatient evaluation and management level. (As of 1/1/2023)

- The physician or APC must ensure that the diagnoses in their assessment are only those addressed at that visit.

- The documentation submitted must display medically necessity, and the physician or APC must have personally performed the work described during that encounter.

- Documentation to support services rendered needs to be patient-specific and date of service-specific.

• The CPT code(s) may be disallowed if any of the following are found:

- Indiscriminate use of the copy/paste functionality that results in inaccurate coding

- Contradictions found in the body of the progress note

- Unnecessarily lengthy/redundant progress note (chart bloat)

- Propagation of false information which may lead to medical errors

- Inability to identify provider thought process

- Inability to follow the care of the patient

Select Health Supervision Standards
Supervision of interns, residents, or any other hospital/facility employees is not reimbursable under any physician fee schedule. These services are reimbursed to the hospital/facility under DRG, APC, or Revenue Codes.

Select Health Addendum/Amendment Standards
Late entries, addendums, or corrections to a medical record are justifiable if additional information that was omitted from the original entry needs to be added to the medical record or a correction to documentation needs to be made.

The use of addendums in a medical record is reasonable, as long as they are added by the clinician providing the original service, are done as soon as possible (i.e., no more than 90 days from the date of the original service), are written only if the person documenting can remember the omitted information, and if both the original and added documentation explain the rationale for the addendum.

Information in the medical record should never be deleted, obliterated, or altered after the fact.

Correction of electronic records should follow the same principles, both the original entry and the correction should reflect the current date, time, and reason for the change. When a hard copy is generated from an electronic record, both records must be corrected. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include: 1) Creation of new

records when records are requested; 2) Back-dating entries; 3) Post-dating entries; 4) Pre-dating entries; 5) Writing over; or 6) Adding to existing documentation (except as described above).

Corrections to the medical record legally amended prior to a medical appeal/review will be considered in determining the validity of services billed**. (**A "review" would be defined as a process including a medical reviewer also looking at notes/clinical, not just looking at the claim.)

The following is the Select Health addendum/amendment documentation expectations:

- The healthcare professional (i.e., the clinician providing the original service) adding the addendum/amendment to the medical record should legibly make the change(s), sign and date the entry—using the date of the correction, not the date of the original entry.
- Any entries made in error should not be altered. A single line should be drawn through the error(s) so that it is still legible and then signed and dated by the clinician performing the addendum;
- The correct information should be inserted into the patient's medical record using the words "Addendum," "Amendment," or "Correction," and should be provided as soon as possible (i.e., no more than 90 days after the original date of service) and should be dated with the date of the correction, not with the date of the original entry;

If these changes appear in the record following the original appeal/review payment determination, only the original record will be reviewed in determining payment of services billed to Select Health.

Evaluation and Management Services:
Documentation must exist in the patient's medical record to support all claims submitted for Evaluation and Management (E/M) services in compliance with current CMS documentation guidelines.

The following are Select Health documentation expectations for any E/M service:

- The patient's full legal name must appear on the documentation of this encounter;
- The date of service must appear on the documentation of this encounter;
- The name of the physician/clinician performing this service must appear on the documentation of this encounter;
- The E/M encounter should be legibly signed and dated by the physician/clinician performing the service and submitting the claim;
- Either the 1995 or the 1997, CMS Documentation Guidelines can be used when documenting E/M encounters based on the clinical situation;
- We will follow 2019 CMS's ease the burden guidelines, to decrease repetitive clinical documentation when appropriate.
- We will follow 2023 CMS's Office and Other Outpatient Evaluation and Management Services guidelines (As of 1/1/2023)
- Selecting the appropriate level of E/M services is based on the level of Medical Decision Making (MDM) or the total time for E/M services performed on the date of the encounter, supported by documentation (information applicable to this encounter);
- Each encounter should include, at a minimum, the chief complaint, a relevant history, relevant physical examination and findings, an assessment and clinical impression, diagnosis, and plan of care;
- In some cases, the documentation should include more significant information about the presenting problem, a review of diagnostic tests (if applicable), counseling, coordination of care;

- If time is to be considered as a factor in the level of service selection, the documentation must support the total time on the date of the encounter. This includes both face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified HCA. The documentation must report total time spent with the patient using a start and stop time or the total time spent
- The documentation should be signed and dated by the physician/clinician performing this service and submitting the claim.

Medical Decision Making Level of Service:

There are four types of MDM recognized: straightforward, low, moderate, and high. The concept of MDM does not apply to 99211 and 99281.

- MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements:
  - **The number and complexity of problem(s) that are addressed during the encounter.**
  - **The amount and/or complexity of data to be reviewed and analyzed.** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately.
    - Data is divided into three categories:
      - Tests, documents, orders or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)
      - Independent Interpretation of test (not separately reported.)
      - Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported).
  - **The risk of complications and/or morbidity or mortality of patient management.** This includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected after shared decision making with the patient and/or family. Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

Time Based Level of Service:

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It includes time regardless of the location of the physician or other qualified health care professional (e.g., whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent in the performance of other separately reported service(s).

- Physician or other qualified health care professional time includes the following activities, when performed:
  - preparing to see the patient (e.g., review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination and/or evaluation
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures

- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Do not count time spent on the following:

- the performance of other services that are reported separately
- travel
- teaching that is general and not limited to discussion that is required for the management of a specific patient

Hospital/Facility Service (Inpatient, Outpatient, Emergency Room): Documentation must exist in the patient's medical record to support all claims submitted for any service in compliance with current CMS documentation guidelines.

- Services rendered by hospital employees (e.g., Physician Assistants, Registered Nurses, Certified Nurse Practitioners, Certified Registered Nurse Anesthetists, Interns, and Residents) that are countersigned by an attending or emergency room physician are not reimbursable as a physician service;
- Countersignatures by an attending physician of another physician/clinician orders or notes are not acceptable documentation of an attending physician service. To become a billable encounter the attending physician must supplement the document with his/her own progress note; and
- If a service is billable, the documentation in the patient record must reflect the specific documentation expectations as defined in this document. (i.e., evaluation and management services, consultations, operative reports, etc.).

Consultations:
Consultation codes 99242−99245 (office/outpatient) and 99252−99255 (inpatient) will not be codes accepted by Select Health.

Providers who bill for these services will have the claim returned with a message indicating that Select Health uses another code for reporting and payment of these services.

It will be appropriate to use the E/M services 99202−99215 (office/outpatient) and 99221−99223 (hospital). The principal physician of record should append modifier, "AI" Principal Physician of Record, to the E/M code used.

The documentation of these services should reflect the Select Health documentation expectations as found in the *Evaluation and Management Services* section of the document.

Operative Reports: Minor

Surgical Procedures

- Regardless of location, the documentation in the patient record should clearly indicate:
    1. Patient's full legal name;
    2. Date of the procedure;
    3. Name of physician/clinician performing the procedure;
    4. Name of the procedure;
    5. Indication (reason for the service);
    6. Anesthetic agent used and how administered (if applicable);
    7. Surgical process (technique used); and

8. Outcome: the procedure note can be incorporated into the office/clinic note or inpatient/outpatient record; and the procedure note should be legibly signed and dated by the physician/clinician performing the service and submitting the claim.

Major Surgical Procedures

o Regardless of location, the documentation in the patient record should be a stand-alone document that includes:

1. Patient's full legal name;
2. Date of the procedure;
3. Name of surgeon(s) and assistant(s) performing the procedure;
4. Name of anesthesiologist(s) and assistant(s) providing the anesthesia services;
5. Pre-operative diagnosis, postoperative diagnosis;
6. Anesthetic agent used and manner of administration;
7. Description of the findings, techniques, and procedure;
8. Any laboratory or diagnostic procedure(s) ordered;
9. Estimated blood loss; and
10. Outcome and condition of patient.
11. The operative note should be legibly signed and dated by the physician/clinician performing the service and submitting the claim.

Anesthesia:

When the anesthesiologist is supervising one or more anesthetists or residents, the supervising physician's presence and intervention must be documented on the anesthesia record. (See "Supervision Standards" for more information)

Anesthesia records should contain two specific elements: a pre-anesthesia evaluation and an anesthesia report.

Within the documentation of the anesthesia services, Select Health documentation expectation includes the following:

1. The patient's full legal name;
2. The date of service;
3. The performing physician/clinician's name; and

Pre-anesthesia evaluation

Documentation in the patient record should clearly indicate that this encounter took place prior to the patient's transfer to the operating area and before pre-operative medication has been administered;

1. Indicate the surgical or obstetrical procedure anticipated;
2. Contain information relative to the choice of anesthesia (general, spinal, or other regional or conscious sedation); and
3. Include the patient's previous medication history, other anesthetic experiences, and any potential anesthetic problems; and
4. The pre-anesthesia evaluation should be legibly signed and dated by the physician/clinician providing the service.
5. If this service is for a patient in active labor, the documentation should clearly identify periodic evaluations of the patient during labor.

Anesthesia Report

The anesthesia report should clearly indicate the name of the anesthesiologist(s) and/or anesthetist(s) who performed the anesthesia service;

1. The patient's condition immediately before the induction of the anesthetic should be documented;
2. The start and end time;

3. All pertinent events during the induction, maintenance of, and emergence from the anesthesia; and
4. The anesthesia report should be legibly signed and dated by the physician/clinician submitting the claim.

Laboratory, Pathology, Radiology, Cardiology, and Other Ancillary Tests

In all cases the reason for, reports of and/or results/findings of tests should be documented and/or referenced in the patient's medical record by the ordering physician.

The report specific to the "interpretation" should include the following:

1. Patient's full legal name;
2. Date of the service;
3. Name of physician/clinician performing the service;
4. Name of the requesting physician/clinician;
5. The indication for the service;
6. The interpretation and/or findings and recommendations (if applicable); and
7. The report should be legibly signed and dated by the physician/clinician performing and submitting the claim.

SELECT HEALTH MEDICARE (CMS)

Select Health Medicare **will follow the commercial plan policy.**

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care **will follow the commercial plan policy.**

Applicable Codes

All HIPAA compliant code sets

Sources

1. American Health Information Management Association® (AHIMA), http://www.ahima.org
2. American Hospital Association (AHA), http://www.aha.org
3. American Medical Association (AMA), http://ama-assn.org
4. Buck, C. J, & Koesterman, J. G. (2020). *Buck's The Next Step: Advanced Medical Coding and Auditing, 2019/2020 Edition*. St. Louis, MO: Elsevier Inc.
5. CMS. (2024, August 9). Medicare Program Integrity Manual Chapter 3 - Verifying Potential Errors and Taking Corrective Actions. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf
6. CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. (2023, January 1) from https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf *Current Procedural Terminology (CPT®)*, (2024) – American Medical Association.
7. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-P). Retrieved January 9, 2019. https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#print
8. Medicare Claims Processing Manual. Issued August 15, 2024. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf
9. 2025 ICD-10- CM Official Guidelines for Coding and Reporting https://www.encoderpro.com/epro/rcpDocHandler.do?_a=view&_dk=ICD10_CM_Guidelines

treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at (801) 442-3692.