



CLINICAL PAYMENT AND CODING POLICY GUIDELINE

This policy is intended to provide guidance on medical record documentation. This guideline is not focused on clinical diagnoses or codes. Providers may have other standards to which they must comply, including but not limited to; federal, state and accreditation standards. If those standards exist those standards will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry-standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code edit protocols for services/procedures billed.

Medical Record Documentation Guidelines

Policy Number: CPCPG001

Version 1.0

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Description

To help ensure submission of medical record documentation is pertinent, accurate, complete and legible for all services performed.

Documentation Guidelines

Illegible, Missing or Incomplete Signatures

Medical records submitted to substantiate services rendered or ordered must be appropriately signed and credentialed.

Acceptable signatures include handwritten signatures or initials over a typed or printed name or authenticated electronic signatures. An electronic signature usually contains a date and timestamp, and a printed statement such as “electronically signed by” or “verified/reviewed by,” followed by the practitioner’s name and professional designation. Stamped signatures are not acceptable, nor are indications that a document has been, “signed but not read.”

The credentials of the provider rendering the service must also be listed somewhere on the medical record; either following the signature, in the typed or printed name or in the letterhead area of the record.

Timeliness of documentation

It is expected that documentation will be generated at the time a service is rendered or “as soon as practicable after it is provided to maintain an accurate medical record”. This is from the Centers for Medicare and Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04 Chapter 12. CMS does not provide any specific period, but a reasonable expectation would be no more than 24-48 hours away from the service itself. Delayed entries within a reasonable time are acceptable for purposes of clarification, error correction, addition of information not initially available, or if unusual circumstances prevented the generation of the note at the time of service. Anything after 48 hours may be considered unreasonable, as providers cannot be expected to recall specifics of services rendered after time has passed. Providers should comply with this requirement and complete documentation in a timely manner. Additionally, entries should never be made in advance of a service being rendered.

Inappropriately altered or addended medical records

The medical record cannot be altered. Any errors identified after the original record is complete must be legibly corrected in a manner that allows the reviewer to identify what is being corrected and why.

If you need to make a correction to a written medical record, you should never write over, erase or delete the original entry. You should draw a single line through the erroneous information, leaving the original entry still legible. Sign or initial and date the deletion and include a reason for the correction above or in the margin or within the correction. Document the correct information with the current date and signature or initial.

Electronic records should follow the same principle of being able to identify the original entry, the correction, the date of the correction, the reason the record is being corrected and the person making the correction. Any hard copies of the electronic record must show the original entry and the correction.

An addendum is used to add information to a record that was not available at the time of the original entry. Addendums should be added timely as the provider must be able to recall the details of the patient encounter. Addendums should be an exception rather than a routine for the practice.

To properly addend a medical record, the provider must, at a minimum, include the following details in the medical record:

- A statement indicating that the entry is an addendum
- The date the record is being amended
- The details of the amended information
- The signature of the provider writing the addendum



Templated, Copy and Paste or Cloned Medical Records

Templates can be useful tools; however, providers should use caution when using templated language. Blue Cross and Blue Shield of Texas discourages templates that provide limited options and/or space for the collection of information, such as checkboxes, predefined answers, choices to be circled etc. Templates that just elicit selected information for reimbursement purposes are often not sufficient to demonstrate that coverage and coding requirements have been met. Templates may also encourage over- documentation to meet these requirements even when services were not medically necessary or were not even delivered.

Templates also make every patient visit or treatment appear the same. Each medical record must be specific to the individual patient. The reviewer of the chart must be able to discern the patient’s condition and services. Atypical patients may have multiple problems or additional interventions that must be documented in detail.

Documentation is considered cloned or “copy and paste” when each entry in the medical record for a patient is worded exactly alike or similar to the previous entries or when medical documentation is exactly the same from patient to patient. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment. Documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter.

Illegible Medical Records

All entries in the medical record must be legible to another reader so that a meaningful review may be conducted.

Legibility of medical records is not just a billing or compliance issue; it is a patient care issue. Illegible documentation may result in medication errors and incorrect diagnoses and procedures being assigned to the patient.

It is especially critical that the identity of the provider of the service be legible.

References:

Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions (Rev. 819, 08/17/18)

Policy Update History:

Approval Date	Description
11/28/2018	New policy
10/17/2019	Annual Review