If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSOK may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from 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"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Medical Record Documentation Guidelines

Policy Number: CPCP029

Version 5.0

Clinical Payment and Coding Policy Committee Approval Date: September 22, 2021

Plan Effective Date: September 22, 2021

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 credential 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.

Time-based services documentation

For time-based service(s), ensure that the documentation contains the duration (e.g. start and stop times – preferred by the Plan), the issues addressed, and the signature of the service provider.

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 and time 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 and time 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 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.

Medical record documentation can only be carried forward when the information contained has been updated to reflect the current date and time of the patient's condition. Providers are responsible for performing the documented services within the medical record. Patient-specific information cannot be copied from another provider's entry without accrediting the original author.

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.

Drug Testing & Other: Documentation Requirements

Orders for diagnostic tests, including laboratory tests, must be patient specific and include the rationale/need for the test requested. Panel testing is restricted to panels published in the current CPT manual. Orders must be signed and dated by the ordering health care professional. "Custom" panels are not specific to a particular patient and are not reimbursable Additionally, these services are not reimbursable: **Routine screenings**, including quantitative (definitive) panels, performed as part of a clinician's protocol for treatment, without documented individual patient assessment.

Standing orders, which are routine orders given to a population of patients and may result in testing that is not individualized, not used in the management of the patient's specific medical condition and **Validity testing in urine drug testing**, is an internal process to affirm that the reported results are accurate and valid. Claims that are accompanied by medical records that do not meet documentation requirements will not be reimbursed. If validity testing is abnormal then subsequent testing of the sample is not reimbursable.

The clinician's documentation must be patient specific and accurately reflect the need for each test ordered. For example, each drug or drug class being tested for must be indicated by the ordering clinician in a written order and documented in the patient's medical record.

Outpatient/Reference Laboratories that submit testing claims should possess, at a minimum, the following:

- A signed, valid requisition form from the ordering provider that specifies the tests being ordered, and
- Complete results of the tests performed.

Urine drug testing requisition form should include the following:

- A list of the specific drugs or drug classes being tested. Reference to a standard order or a "custom panel" is not acceptable; "Reflex" (or automatic) testing is not acceptable
- The identity of the patient;
- The identity of the ordering provider, including full name, credentials, and NPI number;
- A legible signature from the ordering physician (not a stamp or photocopy, and it is not acceptable to state that the physician's signature is on file);
- The facility and location where the sample was collected (e.g., office, home, hospital, residential treatment center);
- The type of sample (i.e., urine);
- The date and time the sample was collected;
- The identity of the individual who collected the sample; and
- The date and time the sample was received in the laboratory.

Lab results should contain the following:

- The complete identification of the entity performing the testing (including name, address, and CLIA number);
- The patient's name and date of birth;
- The ordering provider's name and NPI number;
- Facility name, if applicable;
- The date the sample was collected;
- The date the sample was received in the laboratory;
- The date the test results were reported; and
- Complete test results, including validity testing if performed

Independent laboratory claims should be submitted to the Blue Cross and Blue Shield plan in the state where the referring/ordering provider is located, regardless of where the testing laboratory is located.

References:

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

Medicare Learning Network (MLN)
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo

Policy Update History:

Approval Date	Description
11/28/2018	New policy
10/17/2019	Annual Review
02/06/2020	Policy name revision from CPCPG001, Disclaimer update
03/31/2021	Annual Review
09/22/2021	Updated verbiage