Documentation Requirements for Health Practitioners

LOB(s): ☒ Commercial ☒ Medicare	State(s): ☒ Idaho ☒ Montana ☒ Oregon ☒ Washington ☐ Other:
☒ Medicaid	☒ Oregon ☐ Washington

Enterprise Policy

Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Guideline and the Member's policy, the Member's policy language shall control. Guidelines do not constitute medical advice nor guarantee coverage.

Background

Quality health care and accurate billing is based on rigorous and complete clinical documentation in the medical record. Complete and clear documentation is also critical to timely review for reimbursement of services. PacificSource requires sufficient documentation to meet policy requirements and regulatory compliance as well as ensure compliance with generally accepted best practice guidelines. This policy is intended to cover the basic documentation requirements. Additional requirements may be needed per treatment specific policies, procedures, criteria-based guidelines, and regulatory requirements used by and applicable to PacificSource.

All services shall be provided by staff within the scope of practice of the individual delivering service. Clinicians will follow scope of practice specific requirements determined by regulations, including those of the applicable licensing governing boards.

Criteria

Commercial, Medicaid and Medicare

I. Physical, Behavioral and Oral Health Documentation Requirements

A. General Procedures/Services Documentation Requirements

PacificSource requires **ALL** clinical documentation to meet the following requirements:

- Be complete, legible, and comply with signature and date requirements;
- Document date of service on every entry;
- Reflect the encounter was documented during the session or as soon as practical thereafter to maintain accurate documentation of services;

- Support the level of service provided, including PacificSource policy requirements;
- Use only standardized abbreviations or acronyms, when applicable;
- Be original entries and not be copied and pasted (i.e., duplicative, or identical to other clinical notes) into the clinical record;
- Include and demonstrate medical necessity in each clinical note.

II. Initial Assessment or Exam Documentation Requirements

PacificSource requires physical and behavioral initial assessments or dental exams to include, but are not limited to the following components:

- Complete member identification; name or identification number on each page of the record;
- Reason for encounter, presenting problem(s)/problem list which includes significant illness(es), physical, behavioral, or dental condition(s), as applicable, and precipitating factors;
- Medical history, including but not limited to prior medical history (e.g., accidents, operations, illnesses, etc.), physical exam, and allergies and adverse reactions, as applicable. Current medications should also be listed along with the name of prescribing medical provider;
- Behavioral health history and current medications including name of prescribing medical provider, as appropriate;
- Psychosocial history (elements may include developmental and family history, etc.);
- Subjective and objective exams, including mental status exam, as appropriate;
- Evidence of coordination of care for physical, behavioral, and oral health needs, as appropriate;
- Review of risk factors (e.g., cigarettes, substance abuse, or risk-taking behaviors);
- Laboratory and other diagnostic studies;
- Working physical, behavioral, or dental diagnosis, as well as the appropriate procedural codes (e.g., CDT codes) or diagnosis codes (e.g., ICD-10);
- ASAM Dimensions 1 through 6 assessment, if member requires substance use disorder treatment;
- Treatment plan, clearly stating proposed treatments and level of care, and unresolved problems to be addressed in subsequent visits;
- Clinical justification for proposed level of care, instructions, and proposed treatment recommendations;
- Name and credentials of provider completing assessment.

III. Follow-Up Encounters Documentation Requirements

PacificSource requires documentation of on-going member care. Follow-up assessments and procedures may require components from the initial assessment or exams, as listed above. In addition, follow-up encounters components must include, but are not limited to the following:

- Reason for encounter and relevant history;

- Type of service provided, setting, level of care, and participants present;
- Diagnosis, assessment, and clinical impressions;
- ASAM Dimensions 1 through 6, if the member requires substance use disorder treatment;
- Member's current clinical status, including member's progress, response, and changes in treatment in objective and measurable terms;
- Consultant reports, laboratory or other diagnostic tests completed since the previous assessment;
- Plan of care or treatment goals addressed;
- Appropriate risk factors;
- Rationale or clinical justification for provided services and continued treatment, if requested;
- Instructions for follow up, if applicable;
- For time-based services, include total face to-face time with patient;
- Name and credentials of provider facilitating the treatment.

Related Policies

Care of the Surgical Patient

Clinical Criteria Used in UM Decisions

Guidelines for Submitting Evaluation and Management Codes for Payment

Medicaid and Medicare Authorizations

Medical Record Signature and Date Requirements

Office and Other Outpatient Evaluation and Management (E/M) Visits (99202-99215) and Prolonged Services 99417 and G2212

References

Centers for Medicare & Medicaid Services (January 2021). Complying with Medical Record Documentation Requirements. (2021, January) CMS. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf

Centers for Medicare & Medicaid Services (December 1, 2021). Documentation Matters Toolkit. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Documentation

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National Committee for Quality Assurance. Guidelines for Medical Record Documentation. https://www.ncqa.org/wp-content/uploads/2018/07/20180110_Guidelines_Medical_Record_Documentation.pdf

U.S. Department of Health and Human Services. Office of Inspector General. (2000, October 5). Notices. OIG Compliance Program for Individual and Small Group Physician Practices. 65 Fed. Reg. 59434 and 59435. https://oig.hhs.gov/authorities/docs/physician.pdf

Appendix

Policy Number:

Effective: 5/21/2020 **Next review:** 2/1/2024

Policy type: Enterprise

Author(s):

Dept.: Health Services

Applicable regulation(s): SSA §1902(a)(27) and (30)(A); 42 C.F.R. §440.d230(d); 42 C.F.R. §482.24; NCQA UM 6: Clinical Information; NCQA MA 16: Standards for Medical Record Documentation; Medicaid Services: Article 405 IAC 5-1-5; IDS 54-5711; MCA 24.5.317; OAR 333-505-0050; OAR 410-120-1360; OAR 410-172-0650; WAC 182-502-0020

Commercial OPs: 10/2023

Government OPs: 10/2023