BlueCross BlueShield Nebraska

MEDICAL RECORD STANDARDS

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INTRODUCTION

A medical record documents a patient's medical treatment, past and current health status and treatment plans for future health care, and it is an integral component in the delivery of quality health care. Blue Cross and Blue Shield of Nebraska (BCBSNE) adopted the following medical record documentation standards to ensure providers and suppliers are properly reimbursed.

Each provider/supplier will maintain the patient medical records in a manner that is current, detailed, organized, and permits effective and confidential patient care and quality review. Providers/suppliers will maintain medical, financial, accounting and other records to support medical necessity and document services billed. All information required to support the services submitted on the claim must be in the member's medical record and be available for review.

These standards apply to both electronic and paper-based health records systems. Some record standards may not be applicable for all services. These standards are approved by the BCBSNE Quality Management Committee.

RECORD MANAGEMENT

Maintaining, Retrieving, and Storing Medical Records

Providers/suppliers must maintain all medical and other records in accordance with the terms of their contractual agreement. Medical records will be organized and stored in a manner that allows for easy retrieval and are available to BCBSNE as defined in contractual agreements. Medical records will be safeguarded against loss or destruction and maintained according to Federal and State requirements.

Medical Record Organization

The information in a patient's medical record must be organized according to the following standards:

- There is one chart per patient.
- Each page in the record displays the patient's name or ID number and date of birth.
- Personal/biographical data includes address, employer, home and work telephone numbers, gender, date of birth, emergency contact, and responsible party (as applicable).
- All entries in the medical record contain the author's identification. Author identification may be a handwritten signature or a unique electronic identifier.
- All entries are dated.
- The medical record is legible to someone other than the writer.
- It is not acceptable to obscure portions of the record in any way (for example, white-out, black-out marker, post-it note covering, etc.). This renders that portion of the record illegible and is an alteration of the medical record.

DOCUMENTATION TIPS

- Provide complete and legible documentation.

- Clearly identify medical necessity.
- Use standard abbreviations.
- Include plan of treatment.
- Be careful with software generated documentation, as some include identical entries for different patients/ different dates of service.
- Be careful with check-off sheets; they can be difficult to read, lack findings, be too generic and lack enough space to list specific required information.
- Be careful including non-encounter specific repetitive entries that do not contain policy required components.
- Providers should not add late signatures to medical records, other than a short delay that occurs during transcription process. Use signature authentication process. Retroactive orders are not acceptable.
- Any statements or measurements listed in the “Procedure Performed” Title or Header section of the Operative Report or Procedure Note may not be used to support or select the billed procedure code.[i]

General Medical Record Documentation

Information Filed in Medical Records

The following information must be maintained in a patient’s medical record and dated:

- Past, family, and social history are documented during the first visit and after the patient was seen three or more times. Any history must be initialed and dated by a provider reviewing the information to support an E/M service.
- The existence of an advance directive/living will/power of attorney is prominently documented in each adult (older than 18 years of age) patient’s medical record. Information as to whether the advanced directive has been executed is also noted.
- Documented missed and canceled appointments are included in medical record
- Chief complaint or purpose of visit. The problem list is updated regularly.
- Clinical findings
- Discharge diagnosis or impression (assessment)
- Care rendered, and therapies administered
- Medication list with any current medication and changes in medication with name, dosage, and duration of treatment
- The rationale for ordering diagnostic and other ancillary services
- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed.
- If a consultation was requested, consultant notes

- Consultations by specialists (physician or other), laboratory reports, and imaging reports that are filed in the chart are initialed by the practitioner who ordered them to signify that the ordering practitioner reviewed them. Review and signature by professionals other than the ordering practitioner do not meet this review requirement. If the reports are presented electronically, or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
- Reports, care plans, histories, physicals, progress notes and other patient information with patient notification of findings
- Records of hospital discharge summaries, emergency department visits, home health nursing reports and physical therapy reports
- Health care professional verifies the contents of the record

All documentation in the medical record must be patient specific. Cloning of documentation which fails to consider patient specific variations will be considered a misrepresentation of the medical necessity requirement for coverage of services.

Authenticating (Signing) Medical Records[ii]

Authentication is the process of providing proof of authorship. It signifies knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format, and is accomplished with a handwritten or electronic signature.[iii]

All medical record entries must include (among other things) a legible, dated provider signature. Additionally:

- Providers should not add late signatures to the medical record, other than those that result from the short delay that occurs during the transcription process. Retroactive orders are not acceptable.
- Medical record entries completed by a scribe must be authenticated by the treating provider's signature and date.
- If the signature is illegible, providers may submit a signature log or attestation to support the identity of the signer.

Amending Medical Records[iv]

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record must be signed and dated by the person making the addition or change. The entry must be identified as an amendment to the medical record. These entries must occur during the usual course and business and may not occur post medical record request.

Late Entry: A late entry supplies additional information that was omitted from the original entry. The late entry must include the current date, be added as soon as possible, and written only if the person documenting has total recall of the omitted information and signs the late entry.

> *Example:* A late entry following treatment of multiple trauma might add: "Late Entry: The left foot was noted to be abraded laterally. Jane Doe MD 06/15/09"

Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.

> *Example:* An addendum could note: "Addendum: The chest x-ray report was reviewed and showed an enlarged cardiac silhouette. John Doe MD 06/15/09"

Correction: When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, referring to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date and reason for the change with the signature of the person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. 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.

Required Documentation for Specific Services

Some services require more documentation than is included in the General Medical Record Documentation section. Include the additional documentation cited.

Timed Codes[v]

Documentation must support timed procedure codes. List total time for all timed codes for services listed on any single calendar day using CPT codes and the appropriate number of units of service.[vi] The actual **start and stop times must be listed**. If more than one procedure code is billed for the same date of service, then the start and stop times must be separately documented for each specific procedure or time-based service. Following the Medicare 8-Minute Rule, when more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed.[vii]

The time reported should reflect direct one-on-one contact time with the patient. Documented time must reflect the time that the provider spent face-to-face between the patient and the provider providing the service and not just the time the patient spent receiving supervised procedures in the office.[viii]

Documentation in terms of “units” does not constitute documentation of time or duration.

- A unit of time is attained when the mid-point is passed. (This is consistent with the Medicare 8-Minute Rule and CPT manual guidelines on reporting time-based services.)
- Time must be reported in full one-minute increments. Any fractions of less than one minute will not be considered.

- If the amount of time the service was performed is less than 50% of the time described for the procedure code, then the service will not be separately reimbursable, but will be considered incidental to the other services performed on that date.

Documentation Examples

Correct:

- Listing begin-time and end-time for service: “E-stim to cervical neck, 09:30 – 09:45.”

Incorrect:

- Specific number of minutes: “Manual therapy to lumbar spine x 15 minutes.”
- Documenting time in terms of units or quantity: “One unit of pulsed ultrasound was administered.” or “Ther Ex 1 unit.” or “97110 Exercise x 2”
- Documenting time using a range: “Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms.”
- No time mentioned at all.

Chiropractic Services[ix]

BCBSNE considers maintenance therapy as not medically necessary and it is a noncovered service. When further functional or restorative improvement no longer results from continuous ongoing care, and the treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.[x]

In addition to treatment notes, include documentation in the medial record on each of the following for chiropractic services.

Present Illness (Subjective)

Include a description of the present illness, including:

- Mechanism of trauma
- Quality and character of symptoms/problem
- Onset, duration, intensity, frequency, location and radiation of symptoms
- Aggravating or relieving factors
- Prior interventions, treatments, medications, secondary complaints
- Symptoms causing patient to seek treatment

Note: Symptoms must be related to the level of the cited subluxation. A statement that there is “pain” is insufficient. The location of the pain must be described and whether a particular vertebra listed is capable of producing pain in that area.

Physical Examination or X-ray (Objective)

Two of the following four criteria must be documented for a physical examination, if an x-ray is not taken. One of which must be asymmetry/misalignment or range of motion abnormality.

- Pain/tenderness evaluated in terms of location, quality and intensity
- Asymmetry/misalignment identified on a sectional or segmental level
- Range of motion abnormality
- Tissue, tone changes in the characteristics of contiguous or associated soft tissues

Diagnosis
The primary diagnosis must be subluxation, including the level of subluxation. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine.

Plan of Care
The following must be included in the record:

- Recommended level of care (duration and frequency of visits)
- Specific treatment goals
- Objective measures to evaluate treatment effectiveness

Note: Each goal must be measurable and functional. Documentation should support the goals discussed at each visit.

Physical Therapy[xi]

Authentication
Physical therapy examination, evaluation, diagnosis, prognosis and plan of care (including interventions) must be documented, dated and authenticated by the physical therapist (PT) who performs the service. Interventions provided by a physical therapist assistant (PTA) under the direction and supervision of a PT must be documented, dated and authenticated by the PT or the PTA.[xii] The PT must authenticate services outside the PTA's scope of practice.

Examination
Include documentation in the patient medial record on each of the following.

- Diagnosis
- History with system review
- Test and measures
- Objective, functional and measurable data

Plan of Care[xiii]
Include documentation in the patient medical record of:

- Recommended level of care (duration and frequency of visits)
- Specific treatment goals that relate to function
    - Goals must be measurable and time-framed
    - Identify who will accomplish the goal
- Objective measures to evaluate treatment effectiveness
- Clearly stated medical reason and rationale for each modality utilized, especially when utilizing more than one modality to the same area and same session

Encounter Notes
Encounter notes must include:

- Statements that demonstrate the skill required by the PT or PTA, under the supervision, and direction of a PT, not just statements of completion of activities (this can be seen on the flow sheet). Explain why a patient cannot perform their own exercises at home.

- Identification of specific interventions provided, including frequency, intensity and duration as appropriate
- Changes in patient impairment, activity limitation, and participation restriction status as they relate to the plan of care
- Response to interventions, including adverse reactions, if any
- Factors that modify frequency or intensity of intervention and progression goals, including patient adherence to patient-related instructions. Include patient self-report, as appropriate.
- Communication/consultation with providers, patient, family and/or significant other
- Documentation to plan for ongoing provision of services for the next visit(s), which should include, but not be limited to:
    - The interventions with objectives
    - Progression parameters
    - Precautions, if indicated

Reevaluation

Reevaluation notes must be completed every 10 sessions or every 30 days (whichever is less) and include:

- Documentation of selected components of examination to update patient's/client's functioning and/or disability status
- Interpretation of findings and, as needed, revision of goals
- As needed, revision of plan of care, as directly correlated with the documented goals

Flow Sheets[xiv]

Flow sheets must include:

- Date of service, area being treated, and the name of the PT or PTA providing services
- Clearly delineated CPT code with start and stop times
- Activity completed for each CPT code, including name of activity, repetitions, weights, resistance, etc.
- Modalities (parameters, time frame and specific location(s) treated)

Behavioral Health

In addition to those items listed under General Medical Record Documentation, behavioral health medical record must include:[xv]

- The documentation of each patient encounter must include:
    - The date
    - Start/stop times, as needed for timed codes (see Timed Codes section)
    - Reason for the encounter
    - Appropriate history and physical examination including a list of current medical providers
    - Review of laboratory, x-ray data, and other ancillary services, when appropriate
    - Assessment, including severity and imminence of potential harm to self or other
    - Plan for care, including discharge plan if appropriate
    - List of all persons present

    - List of all persons involved
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- The reasons for and results of x-rays, laboratory tests and other ancillary services should be documented or included in the medical record.
- The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient noncompliance.
- The written plan for care must include:
    - Recommended therapeutic interventions
    - Short- and long-term goals/expected outcomes
    - Treatments directly related to diagnosis and medications, specifying frequency and dosage
    - Any referrals and consultations
    - Patient/family education
    - Specific instructions for follow-up
    - Date established and date completed
- Support for the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making
- All entries to the medical record should be dated and authenticated, including provider credentials.

Third-Party Providers/Suppliers

It is the billing provider/supplier's responsibility to obtain supporting documentation as needed from a referring provider's office (for example, physician order, notes to support medical necessity) or from an inpatient facility (for example, progress note).[xvi] As it is the third-party's claims under review, it is the third-party's responsibility to submit the documentation to support their claim.

DMEPOS Suppliers[xvii]

It is the supplier's duty to prove items delivered were the same items identified on claims. Suppliers must maintain proof of delivery for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Any persons with a financial interest in the delivery of the item (such as, suppliers or their employees) are prohibited from signing and accepting an item on the patient's behalf. The signature should be legible. If the signature of the designee is not legible, the supplier/shipping service should note the name of the designee on the delivery slip.

Proof of delivery is required for all items, even those in the member's possession prior to BCBSNE eligibility.

Supplier documentation must include:

- Description of the item delivered to the patient to determine the accuracy of claims coding including, but not limited to:
    - Vouchers
    - Invoices
    - Statements in the supplier records
- Description of the items delivered must be included on the proof of delivery, to be documented as one of the following:

- Narrative description (for example, lightweight wheelchair base)
- HCPCS code
- Brand name/model number

SENDING MEDICAL RECORDS TO BCBSNE

For all medical records requests, please attach the request letter to all medical records and fax or mailed paper copies to the Medical Records address indicated in the request letter. Include all listed documentation, not to be limited to: office notes, treatment records, prescriptions, ordering/referring notes, treatment logs, related consultations reports, and progress notes from another provider that are referenced in your own note. As needed, include a list of commonly used acronyms.

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[i] American Medical Association. "How to Code from an Operative Report." CPT Assistant, Fall 1992, page 23.
[ii] https://med.noridianmedicare.com/web/jeb/cert-reviews/signature-requirements
[iii] https://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/chiropractic-faqs.pdf
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