

2. Medical Record Documentation

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2.1 About the Medical Record

The **Medical Record** documents chronologically the care of the patient. The medical record documentation contains pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes.

The medical record facilitates:

- The ability of the provider and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data that may be useful for research and education

Payers have contractual obligations to enrollees, requiring reasonable documentation that services are consistent with the insurance coverage provided. Insurers will want to validate the site of service, the medical necessity and appropriateness of the diagnostic or therapeutic service provided, and that those services have been accurately reported.

The medical record needs to substantiate the codes billed to the insurer. A properly documented medical record can reduce many of the problems associated with claims processing, and serve as a legal document to verify the care provided. Because the medical record is considered a legal document, it should not be tampered with, falsified, or altered in any manner that would cause the loss of or suppression of data.

2.2 Principles of Medical Record Documentation

The following principles of medical record documentation apply to all types of services in all settings:

- The medical record should be complete and legible.
- There is no specific format required to document the components of the evaluation and management of a visit.
- The documentation of each patient encounter should include
 - Chief complaint and/or the reason for the encounter and relevant history, physical, examination, findings, and prior diagnostic test results
 - Assessment, clinical impression, or diagnosis
 - Plan for care
 - Date and a verifiable legible identity of the health care professional who provided the service
- If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal, intrapartum, and postpartum period that affect the newborn, should be accessible to the treating and/or consulting provider.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
- The medical record documentation should support the CPT and ICD-9 codes reported on the health insurance claim form or billing statement.
- A service should be documented during, or as soon as practicable after it is provided, to maintain an accurate medical record.
- An addendum to a medical record should be dated the day the information is added to the medical record, not the date the service was provided.
- The confidentiality of the medical record should be fully maintained and consistent with the requirements of medical ethics and law.

2.2.1 Medical Record Documentation Guidelines

Communication between the provider and coder is the key to successful coding. The process of assigning a CPT code to a procedure or service is dependent on both the supporting documentation and the procedure recorded. The ICD-9 diagnosis code must be well documented in the medical record and must support the medical necessity of the claim.

The *ICD-9-CM Official Guidelines for Coding and Reporting* is available at this website:

<http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>

Diagnosis codes (ICD-9) need to be selected with care. All diagnoses affecting the current treatment of the patient must be included on the claim forms.

All coding must be accurate, precise, and meaningful to guarantee prompt and accurate payment. Therefore, the coder and the biller should never change billing information documented by a provider without informing the provider. If a provider completes a charge ticket and signs it, or a visit in EHR with an electronic digital signature, that document is a legal record and should not be altered.

Data entry, either by the provider or by the coder, must be completed as soon as possible. For specific outpatient and inpatient billing timeframes, see the *Indian Health Manual, Part 5, Management Services*, Chapter 1, “Third Party Revenue Accounts Management and Internal Controls” (5-1.3H), which is available at this website:

http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part5/pt5chpt1/part5c_hapt1.htm

2.3 Provider Documentation Requirements for Evaluation and Management Codes

For evaluation and management (E&M) codes, the provider must document the following information:

- The chief complaint, a review of systems, and the past, family, and/or social history may be listed as separate elements of the history; or they may be included in the description of the history of the present illness.
- A review of systems and a past, family, and/or social history obtained during an earlier encounter does not need to be re-recorded, if there is evidence that the physician reviewed and updated the previous information.
- A review of systems and/or the past, family, and/or social history may be recorded by ancillary staff or on a form completed by the patient. To document that the provider reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.
- The medical record should
 - clearly reflect the chief complaint
 - describe one-to-three elements of the history of present illness
 - describe at least four elements of the present illness or the status of at least three chronic or inactive conditions
- At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.
- The patient's positive responses and pertinent negative responses for the system related to the problem should be documented.
- The patient's responses and pertinent negatives for two-to-nine systems should be documented.
- At least one specific item from any of the three history areas must be documented for a pertinent past, family, and/or social history.

- At least one specific item from two of the three history areas must be documented for a complete past, family, and/or social history for the following categories of evaluation and management services:
 - office or other outpatient services, established patient
 - emergency department
 - domiciliary care, established patient
 - home care, established patient
- At least one specific item from each of the three history areas must be documented for a complete past, family, and/or social history for the following categories of evaluation and management services:
 - office or other outpatient services, new patient
 - hospital observation services
 - hospital inpatient services, initial care, consultation
 - comprehensive nursing facility assessments
 - domiciliary care, new patient
 - home care, new patient
- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.
- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.
- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

2.3.1 E&M Services Documentation Guidelines

The provider is responsible for indicating the level of service (E&M visits) and any other procedures done for all patients. If the diagnosis and care rendered do not substantiate the level of visit, the coder must return the medical documentation to the provider for review.

There are two versions of the documentation guidelines for E&M services:

- 1995 Documentation Guidelines for Evaluation & Management Services
- 1997 Documentation Guidelines for Evaluation & Management Services

Both versions of the guidelines are available at this website:

http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Note: Although the Indian Health Service recommends using the 1997 Documentation Guidelines, providers can choose to use either the 1995 guidelines or the 1997 guidelines. Thus, carriers must review and adjudicate claims using both the 1995 and 1997 guidelines.

2.4 Customer Service

Customer Service is an important function for providers, coders, and billers both externally and internally. Providers, coders, and billers interact often with insurance companies, auditors, patients, third-party billing agents, and other individuals. Either the external party needs specific information to process their claims or verify documentation, or the provider, coder, or biller needs clarification of regulations, processes, procedures, or requirements for justifying an appeal.

Regardless of the reason, the external environment is dependent on the internal business operations of the facility and vice versa. Therefore, coders, providers, and billers need to

- State specifically their requests in a professional manner.
- Provide timely responses to external requests.
- Document responses and maintain a copy.
- Build working relationships, which will benefit future inquiries.

With regard to the internal, inter-departmental customer service, the entire Business Office staff – Registration, Health Information Management (HIM), Nursing, Providers, Coding, Data Entry, Billing, Account Reconciliation – needs to work as a team to provide, on behalf of the facility, accurate documentation and billing to the insurer. Without this team approach, the written documentation could not be transferred to applicable coding and subsequently, billed correctly to the insurer. The team needs to build strong, collaborative working relationships where everyone relies on the previous person to perform their function.