SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.44 MEDICAL RECORD DOCUMENTATION

MEDICAL RECORD DOCUMENTATION

Medical record documentation should be timely, legible, pertinent, accurate, specific to the patient evaluated and complete.

The patient's written medical record should support any code which is billed. When medical records are illegible, the services are considered not documented. If services are insufficiently documented or not documented, then the medical record does not support the services that were performed. This means the services are not billable to Blue Cross or to the member. Records submitted as illegible are considered not documented, and the request for services will be denied.

Documentation is expected to be generated at the time the service is rendered or within a reasonable time (e.g., 24-48 hours) after the service. It is acceptable to make delayed entries in certain circumstances (e.g., error correction, clarification, additional information not originally available and the explanation documented), however, anything after 48 hours may be considered unreasonable since a provider's ability to recall specific details after that period of time cannot be expected. If there is a delayed entry the record should be updated in a way that allows the identification of the original entry and the correction as well as the individual making the correction. Additionally, clarification should not be submitted by anyone other than the provider who made the initial entry, and the substance of the original entry cannot be eliminated. The date and time of the delayed entry should be noted as well as the reason for the delayed entry. Persistent issues related to a delay in accurate documentation may result in prepayment reviews or a denial of the requested services.

Medical record documentation must be specific to the patient's situation at the time of the service. Each patient will have a unique set of problems, symptoms and treatments, so the expectation is that documentation would not look exactly the same across patients. Cloned medical records from boilerplate text or previous visits are not permitted. The expectation is that medical record entries for a patient would not be worded exactly alike or similar to previous entries. Please be cautious when using templates to generate the medical record to ensure that what is documented in the medical record actually occurred for that patient. Contradictions between templated records and any other notation will be considered not documented.

Accuracy of the medical record is critical. In situations where the medical record contradicts itself or contradicts another document from the same date of service, that portion of the medical record will be considered not documented and will necessitate an addendum to correct the medical record.

For time based codes, the documentation should include the start time and total time that supports the service rendered. Documentation of the number of units does not constitute documentation of the duration of time of the service. If multiple time based services are billed for the same date of service, then the time must be separately documented for each service rendered and it must clearly differentiate each service.

When patient treatment requires multiple visits or is of a repetitive nature, the patient's baseline level of function should be documented along with objective measurements and appropriate care plans. Documentation should include skilled services provided, objectively measured progress toward functional goals and justification for ongoing treatment. Use of pre-populated templates that do not address objective findings will be considered as inaccurate and not reimbursable.