Principles of Medical Record Documentation

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I have reviewed many Medicare and CMS reports from record audits over the years. The one thing that seems to always stand out is the number of audits that are failed due to lack of or inadequate medical record documentation to support any particular claim being reviewed. Certainly, medical record documentation can be tedious and time consuming. However, medical records are the only way to support the medical necessity of any given service billed to an insurance plan. An overview of the Medical Reviews and Process, along with documentation tips from Novitas can be found here. Per Novitas, appropriate medical documentation aids in the following:

1. Ability of provider to evaluate and plan patient's immediate treatment and to monitor health care over time
2. Communication and continuity of care between all health care professionals involved in a patient's care
3. Accurate and timely claims review and payment
4. Appropriate utilization review and quality of care evaluations
5. Collection of data that may be useful for research and education
6. May serve as a legal document to verify the care provided

When the 2021 changes to the Evaluation and Management codes were introduced, many speakers told Optometrists that the examination and medical history documentation no longer matter. This is far from the truth. While the documentation guidelines less "document-by-numbers", the required documentation must still support the medical necessity of the service being provided with an appropriate patient history and appropriate examination elements precisely and clearly recorded.

Medical records should be complete and legible. Each patient encounter documentation should include a clear reason for encounter, any relevant history and past records and history being accessible, all physical examination findings should be recorded along with any previous diagnostic test results. An assessment of any clinical impression or diagnosis should be included along with the plan of care to address the patient needs. All medical records must be signed and dated by the provider according to one of the permissible methods – signature, electronic signature, signature log or attestation. Please keep the old adage "If you fail to write it down, you did not do it" in mind. The physician is considered the responsible party of all information entered into the medical record. Only the provider's signature is now required. Any staff entering information into the medical record no longer have to be individually identified.

Numerous approaches to documentation have been developed over the years. The SOAP method of **S**ubjective findings, **O**bjective findings, **A**ssessment and **P**lan has been around for a very long time. Another approach called MEAT which stands for **M**onitoring, **E**valuating, **A**ssessing, and **T**reatment can be used. Many Electronic Health Records (EHRs) use other approaches. The particular approach used is not as important as ensuring that all important information is clearly written in the medical record. If handwritten, the documentation must be legible.

The use of "Chief complaint" was dropped when the new E&M codes were introduced. In its place is the definition of "Problem(s)". In part, to use Medical Decision Making to choose the appropriate E&M code, a service level is based on the number and complexity of the problems that are addressed at the encounter (as well as any data reviewed and the risk involved in the care decisions). The current CPT® Book defines a problem as "*a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter*." Further, for a problem to be addressed the documentation must show it is evaluated or treated at the encounter by the provider reporting the service and must include consideration of testing or treatments that may or may not ultimately be used. Per CMS, documentation must show that any services and/or supplies used are proper and necessary to diagnosis or treat the medical condition(s) documented. The services must be provided for diagnosis, direct care, and treatment of medical condition, and meet standards of good medical practice in local area and not be mainly for the convenience of the provider or patients.

Be sure to write orders for any testing along with any required interpretation and reports. Documentation should indicate all records reviewed and where any information was acquired. A concise, clear assessment that indicates clinical impressions or diagnoses along with changes in known conditions should be written. The plan must be written and include the rationale for ordering any diagnostic or ancillary services. All information should be entered into the record in timely manner - within 12-24 hours but preferably at the time of service. All original content should be clearly identified and nothing in the medical record should **EVER** be deleted. Any original EHR record should be signed and "sealed" when the timely documentation is completed to prevent further changes. If any amendment, correction or delayed entries are necessary, these should identify the author and date of the addition.

The CMS MedLearn on Medical Documentation was updated in December of 2024. The following was added:

1. CMS can deny payment for services with incomplete or illegible records
2. For valid claim - records must have sufficient documentation to verify the services performed were compliant with all CMS policies and billed at required [appropriate] level of care
3. No documentation or insufficient documentation = No justification for the services or level of care billed
4. For claims already paid, when providers don't include sufficient documentation, any payment made may considered as an overpayment and be partially or fully recover

Other resources:

Medicare Evaluation and Documentation

Active Novitas Part B Targeted Probe and Educate Audits occurring that might impact Optometry

Surgical services: Cataract extraction (CPT 66982-66984)	Active	Cataract results
Evaluation & management (E/M) services: Established office/outpatient visits (CPT 99215, 99214, 99213), Subsequent hospital inpatient or observation care (CPT 99232), New office/outpatient visits (CPT 99204)	Active	Evaluation & Management results

Targeted Probe and Educate Documentation Check List: Cataract Extraction, Benign Skin Lesion Removal, and Evaluation and Management Services.

Review the previous articles on:

Audits Types Providers Need to Understand – November 2024
Responding to Risk Adjustment Audit Records Requests – July 2024
Evaluation and Management Code Selection Using Medical Decision Making – May 2024
The Dangers of Record Cloning- August 2023
Medicare Signature and Medical Record Authentication-June 2023
Documentation Guidance in the Era of the 2021 E&M 2021 Coding Rules- April 2023