Transforming Lives

Clinical Documentation Workshop

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Objectives

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At the end of this session you should be able to:

- Identify Medicaid documentation rules
- Explain that services rendered must be well documented and that documentation lays the foundation for all coding and billing
- Understand the term “Medical Necessity”
- Describe the components of Effective Document of Medical Necessity:
  - Assessment
  - Planning Care
  - Documenting Services
- Identify key elements to avoid repayment and other consequences

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Goals

- Participant will become familiar with Medicaid documentation rules.
- Participant will discover the importance of complete and detailed documentation as the foundation for coding, billing and quality of care for the client.
- Participant will learn how insufficient documentation leads to both poor client care and to improper payments.

Medical Necessity Contract Definition

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- The service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.
- There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable.

Medical Necessity Contract Definition

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- This course of treatment may include mere observation, or where appropriate, no treatment at all.
- Bottom line: the treatment interventions must help the person get better, or at the very least, prevent a worsening of the person's health.

Medical Necessity

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- Requires that all services/interventions be directed at a medical problem/diagnosis and be necessary in order that the service can be billed
- A claims based model that requires that each service/encounter, on a *stand alone basis, reflects the necessity for that treatment intervention

* Stand alone means information in the service note should include pertinent past clinical information, dealing with the issue at hand, and making plans for future care such as referrals or follow up, based upon the care plan. Each service note needs to stand-alone completely.

Why Document Medical Necessity?

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Documentation is an important aspect of client care and is used to:

- Coordinate services and provides continuity of care among practitioners
- Furnish sufficient services
- Improve client care – provides a clinical service map
- Comply with regulations (Medicaid, Medicare and other Insurance)
- Support claims billed
- Reduce improper payments
- Medical record is a legal document

Tests for Medical Necessity

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- There must be a diagnosis: ICD 10
- The services ordered are considered reasonable and effective for the diagnosis
  - Directed at or relate to the symptoms of that diagnosis
  - Will make the symptoms or persons functioning get better or at least, not get worse
- The ordered services are covered under that person's benefit package (State Plan Services)

Golden Thread

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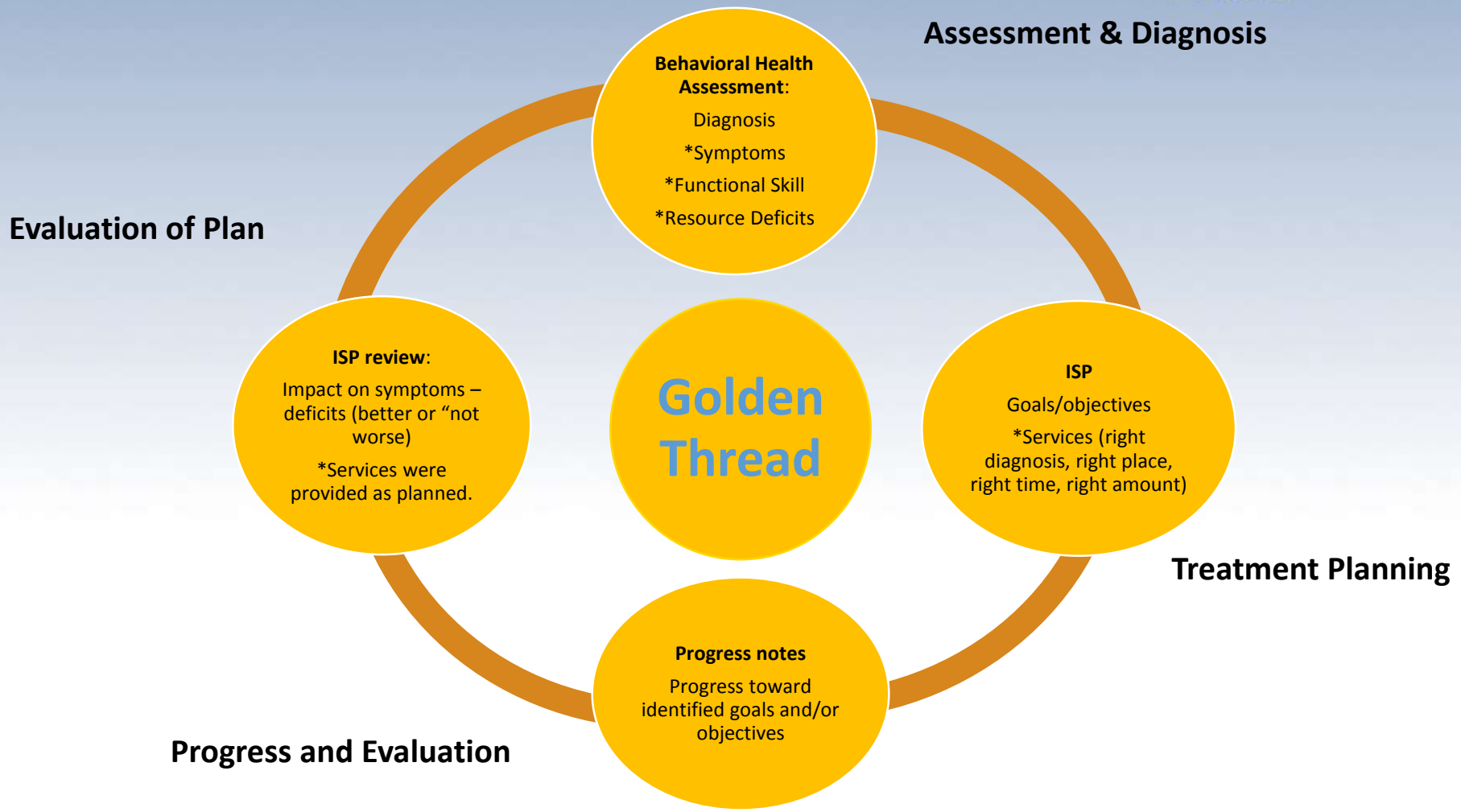

The Intake Assessment

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- Diagnosis with clinical rationale: how the diagnostic criteria are present in the person's life
  - Based on presenting problem (Reflect an understanding of unmet needs relating to symptoms and behaviors)
  - Data from client—their story and the client's desired outcome
  - Observation
- Safety or risks
- Client functioning
  - Evidence that the diagnosis/client condition, causes minimally, moderate distress or functional impairment in Life Domains
- Recommendation for treatment and level of care.

WAC Required Elements for Assessments

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- WAC 388-877-0610
- Clinical—Initial assessment.
- Each agency licensed by the department to provide any behavioral health service is responsible for an individual's initial assessment.

1. The initial assessment must be:
   a) Conducted in person; and
   b) Completed by a professional appropriately credentialed or qualified to provide substance use disorder, mental health, and/or problem and pathological gambling services as determined by state law.

WAC Required Elements for Assessments continued

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2) The initial assessment must include and document the individual's:
   a) Identifying information;
   b) Presenting issues;
   c) Medical provider's name or medical providers' names;
   d) Medical concerns;
   e) Medications currently taken;
   f) Brief mental health history;
   g) Brief substance use history, including tobacco;

WAC Required Elements for Assessments continued

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2) The initial assessment must include and document the individual's - continued:
   - g) Brief problem and pathological gambling history;
   - h) The identification of any risk of harm to self and others, including suicide and/or homicide;
   - i) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment;
   - j) Information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; and
   - k) Treatment recommendations or recommendations for additional program-specific assessment

Additional Assessment Requirements for SUD

WAC 388-877B-0230 (Residential), WAC 388-877B-0330 (Outpatient),
WAC 388-887B-0430 (OST), 338-887B-0530 (Assessment Services)

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- **Substance use disorder residential treatment services—Additional assessment standards.**
- An individual must have a substance use disorder assessment before receiving substance use disorder treatment services. The purpose of the assessment is to gather information to determine if a substance use disorder exists and if there are services available to address the individual's needs. In addition to the assessment requirements in WAC 388-877-0610, the assessment must include:
- (1) A face-to-face diagnostic interview with the individual in order to obtain, review, evaluate, and document the following:
- (a) A history of the individual's involvement with alcohol and other drugs, including:
- (i) The type of substances used, including tobacco;
- (ii) The route of administration; and
- (iii) The amount, frequency, and duration of use.
- (b) A history of alcohol or other drug treatment or education;
- (c) The individual's self-assessment of use of alcohol and other drugs;
- (d) A history of relapse;
- (e) A history of self-harm;
- (f) A history of legal involvement; and
- (g) A statement regarding the provision of an HIV/AIDS brief risk intervention, and any referral made.
- (2) A diagnostic assessment statement, including sufficient information to determine the individual's diagnosis using:
- (a) Diagnostic and Statistical Manual (DMS IV TR, 2000) as it existed on the effective date of this section; then
- (b) DSM-5 as it exists when published and released in 2013, consistent with the purposes of this section. Information regarding the publication date and release of the DSM-5 is posted on the American Psychiatric Association's public website at www.DSM5.org.

Additional Assessment Requirements for SUD

WAC 388-877B-0230 (Residential), WAC 388-877B-0330 (Outpatient),
WAC 388-887B-0430 (OST), 338-887B-0530 (Assessment Services)

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- **Substance use disorder residential treatment services—Additional assessment standards. (continued)**
- (3) A placement decision, using patient placement criteria (PPC) dimensions when the assessment indicates the individual is in need of services.
- (4) Evidence the individual was notified of the assessment results and documentation of the treatment options provided and the individual's choice. If the individual was not notified of the results and advised of referral options, the reason must be documented.
- (5) The additional requirements for DUI assessment providers in WAC 388-877B-0550 if the agency is providing services to an individual under RCW 46.61.5056.
- (6) Documented attempts to obtain the following information when assessing youth:
- (a) Parental and sibling use of alcohol and other drugs.
- (b) A history of school assessments for learning disabilities or other problems which may affect ability to understand written materials.
- (c) Past and present parent/guardian custodial status, including running away and out-of-home placements.
- (d) A history of emotional or psychological problems.
- (e) A history of child or adolescent developmental problems.
- (f) Ability of the youth's parent(s) or if applicable, legal guardian, to participate in treatment.

Additional Assessment Requirements for Mental Health

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- **WAC 388-877A-0130**
- **Outpatient mental health services—Assessment standards.**
- In addition to the assessment requirements in WAC 388-877-0610, an agency providing any outpatient mental health service must ensure the clinical mental health components of the assessment:
- (1) Are provided by a mental health professional.
- (2) Are initiated within ten working days from the date on which the individual or the individual's parent or legal representative requests services, and completed within thirty working days of the initial assessment.
- (3) Gather sufficient information to determine if a mental illness exists, and if there are services available within the agency to address the individual's needs.
- (4) Document presenting problem(s) as described by the individual. The agency may contact the person(s) who provide active support to the individual in order to validate and/or obtain further information regarding the individual's presenting problem:
- (a) Only at the request of the individual, if the individual is thirteen years of age or older; or
- (b) At the agency's discretion, if the individual is twelve years of age or younger.
- (5) Contain sufficient clinical information, including a review of any documentation of a mental health condition provided by the individual, to justify the diagnosis using criteria in the:
- (a) Diagnostic and Statistical Manual (DSM IV TR, 2000) as it existed on the effective date of this section; then
- (b) DSM-5 as it exists when published and released in 2013, consistent with the purposes of this section. Information regarding the publication date and release of the DSM-5 is posted on the American Psychiatric Association's public website at www.DSM5.org.
- (6) Contain a developmental history if the individual is a child.
- (7) Are culturally and age relevant.

Assessment Tips

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1. Check boxes can be helpful to record information, be sure that you include a narrative to support the check boxes.
2. A summary or clinical formulation should be included that supports the diagnosis. Avoid just reporting the diagnosis criteria.
3. If you receive an assessment from another agency that was completed within the past 12 months, you should update the assessment to ensure it provides a current presentation.

Individual Service (Treatment) Plan

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A Quality Plan should:

- be linked to needs identified in the assessment
- include desired outcomes relevant to the presenting problems and symptoms and utilize client's words (How client knows when they are ready for discharge)
- have a clear goal statement
- include measurable objectives (how will practitioner and client know when an objective is accomplished)
- use client strengths and skills as resources
- clearly describe interventions and service types
- identify staff and staff type. (The staff should be qualified to deliver the care)
- address amount, duration and scope of interventions

Individual Service (Treatment) Plan

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- § 440.230 Sufficiency of amount, duration, and scope.
- (a) The plan must specify the amount, duration, and scope of each service that it provides for -
- (1) The categorically needy; and
- (2) Each covered group of medically needy.
- (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
- (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.
- (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
- [46 FR 47993, Sept. 30, 1981]

Center for Medicare and Medicaid Services

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4221. Outpatient Psychiatric Services

E. Periodic Review.--The evaluation team should periodically review the recipient's PoC in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient's continued participation in the program. The evaluation team should perform such reviews on a regular basis (i.e., at least every 90 days) and the **reviews should be documented in detail in the patient records**, kept on file and made available as requested for State or Federal assessment purposes.

Progress Notes

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Progress notes must reflect the providers delivery of services, according to the nature, frequency, and intensity 'prescribed' in the treatment plan. Progress notes back up specific claims & justify payment. Progress notes must be authored by the service provider.

Progress notes provide evidence of:

- The covered service delivered
- The Individual's active participation
- Progress toward the goals and objectives
- On-going analysis of treatment strategy and needed adjustment
- Continued need for services (medical necessity)

Progress Notes continued

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- Must be written for each encounter
- Must address the goals and objectives of the treatment plan
- Must document the intervention via the services ordered by the treatment plan
- Services not tied to the treatment plan need to be clearly identified.
  - Rule of 3 – If a service not on the treatment plan occurs more than 3 times it must be added to the treatment plan
  - "intervention is not part of the treatment plan"
- If different services are needed: plan must be revised

Progress Note Elements

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- Date of Service
- Start time and duration
- Goal and/or objective
- Location of service
- Service code (local or CPT/HCPC)
- Medical necessity (purpose of encounter)
- States the intervention(s) used: techniques targeted to achieve the outcomes provider is looking for
  - More specific than just “individual therapy”
- Assessment and clinical impression

Progress Note Elements continued

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- Client response to the intervention
  - Were they able to demonstrate the skill or participate in role playing?; Could they list how to apply the skills being taught? Or did they not get it, refuses to participate, resist, etc.
- Plan for next interaction
- Optional: homework assignment or other task to complete before the next visit
- Note must be legible
- Legible signature of the provider
- Date the actual progress note was completed

Center for Medicare and Medicaid Services

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4221. Outpatient Psychiatric Services

D. Documentation.--The outpatient program should develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, should consist of material which includes:

1. the specific services rendered;
2. the date and actual time the services were rendered;
3. who rendered the services;
4. the setting in which the services were rendered;
5. the amount of time it took to deliver the services;
6. the relationship of the services to the treatment regimen described in the PoC

AND

7. updates describing the patient's progress.

Center for Medicare and Medicaid Services - continued

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For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

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Examples

Example 1:

Date: 08/01/2015	**Start time:** 1:30pm
Location: 99-other place of service	**Duration**: 240 min
Provider type: 05- Below Master's Degree	**Code**: H0004 U8- behavioral health counseling and therapy

- **Progress note**: Went to the clients home to provide additional support because the client was refusing to go on the family vacation.
- **Assessment**: client was open to the idea and was respectful.

- What are the key elements of the progress note present?

Medical Necessity	
Intervention	
Individual Voice	
Individual Response	
Objective/Link to ISP	
Progress	
Plan/Next Steps	

Answer to Example 1:

Key Elements with the Progress Note:

Medical Necessity	**Not provided**
Intervention	Not clear what “additional support” was provided
Individual Voice	Not provided
Individual Response	Not clear (open to idea – not sure what idea?)
Objective/Link to ISP	Not provided
Progress	Not provided
Plan/Next Steps	No plan identified

Note did not identify the management, reduction or resolution of the identified problems.

Example 2:

Date : 08/25/2015	**Start time:** 1:30pm
Location: 99-other place of service	**Duration**: 55 minutes
Provider type: 4- MA/Ph.D	**Code**: 90847- Family Therapy with Individual

- **Progress note**: Joe's mother, Sally, reports that she offered choices (a parenting technique from last week's session) in order to set limits with Joe on two occasions this week, instead of previous practice of yelling at Joe. She reports that Joe was able to make a "good choice" (i.e., not have an angry outburst) on one of these occasions, which represents an improvement as Joe previously "almost never" made a "good choice" per Sally. Sally agreed to continue trying to remember to offer Joe choices instead of yelling this coming week, say she will attempt to offer choices three times. Reviewed with Joe and Sally reciprocal trust and security for both Joe and Sally as they continue to develop a more mutually responsive relationship. We also reviewed several behavioral observations which indicate behavioral triggers for Joe, e.g. being late for pick up, eating a late dinner and brushing teeth. Practitioner reframed the behavioral observations for Sally towards understanding that Joe is communicating his fear and possible anxiety and his outbursts are a function of his desire for getting his needs met. Next session we will continue to build on sustainable relationships and behavior identification.
- What are the key elements of the progress note present?

Medical Necessity	
Intervention	
Individual Voice	
Individual Response	
Objective/Link to ISP	
Progress	
Plan/Next Steps	

Answers to Example 2:

Key Elements with the Progress Note:

Medical Necessity	Anxiety/anger outburst
Intervention	Reframing. Reviewed behavioral observations which indicate behavioral triggers for Joe
Individual Voice	Report of making good choices: "almost never" "good choice" (mother reports improvement)
Individual Response	Agreement improvement and to continue offering choices technique
Objective/Link to ISP	Offering choices (parenting techniques) – setting limits
Progress	Improvement note (making good choice)
Plan/Next Steps	Next session will continue to build on sustainable relationships and behavioral identification.

Example 3:

Date : 8/10/2016	**Start time: 10:30 a.m.**
Location: 57	**Duration**: 30 minutes
Provider type: 20 - CDP	**Code**: H0020

- **Progress note**:

Problem: Patient has a history of opiate dependence which interferes with his recovery. Patient lacks sober activities, and states "I would really like to ride a motorcycle again."

IPS Goal discussed during session today: Drug Use and Medical Issues

Patient attended an individual session on this date. Patient reported that he "used methamphetamines the day before." Patient also reported that he "still wanted to maybe get a membership at the YMCA, so that he can get some of his health issues under control." Patient discussed attempting to discontinue his substance use, and reported that he "would quit using when he had 7 positive UA's." Patient discussed thinking over quiting before that, and stated that "he would."

Patient continues to make some progress, was verbal, attentive and was positive throughout the session. Patient appears to be in the pre contemplation stage of change as evidenced by his continued substance use, and the lack of motivation to quit.

Counselor will continue to monitor and assist patient on identifying ways to discontinue his substance use. Scheduled Patient's next individual session for 8/10/2016 at 10:30 a.m.

Plan: Patient will work on getting YMCA membership, as well as discontinuing his substance use. Patient will continue to attend daily dosing, weekly counseling, medical appointments and random UA's. Patient will work toward complete abstinence from all substance use.

- **What are the key elements of the progress note presented?**

Medical Necessity; Intervention; Individual Voice; Individual Response; Objective/Link to ISP; Progress; Plan/Next Steps

Answers to Example 3:

Key Elements with the Progress Note:

Medical Necessity	Active Opiate Use
Intervention	No intervention provided
Individual Voice	Individual quotes were present that demonstrated the lack of progress in treatment and pre-contemplation stage of change
Individual Response	Individual is not responding to treatment, continued use reported
Objective/Link to ISP	General statement: Drug use and Medical Issues
Progress	Not sure where individual previously was in his recovery, so hard to rate if progress is noted.
Plan/Next Steps	Plan starts with obtaining YMCA membership and then describes the treatment plan. This section is about what the individual or clinician will be doing to assist the individual in treatment. Example: Individual will work on identifying three reasons why he should quit use and three reasons why he should wait and bring to next individual session.

H0020: Outpatient OST services provides assessment and treatment to opiate dependent patients. Services include prescribing and dispensing of an approved medication, as specified in 21 CFR Part 291, for opiate substitution services in accordance with WAC 388-877B. Both withdrawal management and maintenance are included, as well as physical exams, clinical evaluations, individual or group therapy for the primary patient and their family or significant others. Additional services include guidance counseling, family planning and educational and vocational information. The service as described satisfies the level of intensity in ASAM Level 1.

Example 4:

Date : 03/20/2015	**Start time: 7:45pm**
Location: 23- Emergency room hospital	**Duration**: 255 min
Provider type: 4- MA/Ph.D	**Code**: 90847- family psychotherapy with patient present

- **Progress note**: Safety and determining stay location after discharge from ED. Staff met family at the Emergency Room after they called and said that client tried to grab a knife and cut himself and go after family members. Family members stated that they were done a month ago but that today was the last straw. They are scared for family safety. They do not want to have him home. Staff will look into short term stay location for him and will check in on him tomorrow.

- What are the key elements of the progress note present?

Medical Necessity	
Intervention	
Individual Voice	
Individual Response	
Objective/Link to ISP	
Progress	
Plan/Next Steps	

Example 5:

Date : October 9, 2017	**Start time: 1:00 p.m.**
Location: 57 – Substance Use Facility	**Duration**: 90 minutes
Provider type: 20-Chemical Dependency Professional	**Code**: 96153 Health and behavior intervention

- Group members checked in and processed their week. Group viewed video "Ingredients for Recovery"(30 min) followed by discussion and opinions on recovery programs.
- D) Frank reported nothing eventful occurred this week. He was sent home early from work because it was slow. Frank stated his last use of alcohol and marijuana was in September before he went to court.
- A) Frank is acclimating to group.
- P) Frank to continue with treatment plan as written

What are the key elements of the progress note present?

Example 6:

Date : January 4, 2017	**Start time: 3:00 p.m.**
Location: 57	**Duration**: 120 minutes
Provider type: 20 Chemical Dependency Professional	**Code**: 96153 Health and behavior intervention

- Group members checked in, processed their holiday weekend (New's Year's Eve), shared objectives and peer support/feedback.
- Roger shared that he did not drink alcohol over the holiday weekend. He spent time with family. Roger shared that he went to a self help group over the weekend.
- Roger shared treatment objective A, B Dimension 5 Continued Use: At his individual session he agreed to work on treatment objectives that address his down time/computer time with healthier activities. He tends to isolate self at computer and drink alcohol. Objectives A & B: Replace computer use between 3:00-6:00 p.m. with healthier activities. Include spouse in decreasing computer time (share more time with her/exercise, household chores, etc.) His urine drug screen collected on 12/16/2016 was positive for alcohol. At his individual session he shared that he drinks while on the computer. Roger shared that he was successful in objective A: less time on computer/replace time with other activities. B: Include wife in his plan. He hasn't mastered this task, although wasn't as bad as he thought it may be.
- A) Roger was active in treatment plan objective sharing.
- P) Roger will attend next scheduled session on
- 01/04/2017. He will continue to work on treatment objectives throughout the month and report back to group.

- **What are the key elements of the progress note present?**

Example 7:

Date : 4/28/2016	**Start time: 1:30 p.m.**
Location: In community	**Duration**: 90 minutes
Provider type: Peer Specialist	**Code**: H0038

- **Progress note**: This writer met at client' home to discuss self care goals and discuss coping skills for anxiety and depression. Client arrived to the meeting location on time and presented with good hygiene and grooming. When this writer inquired, client stated that she had not had any homicidal or suicidal thoughts, means or intent since our last session. When this writer arrived to client's home, client indicated that she had an immediate need to pick up essential medication. Client and this writer went to pick up client's medications. Client and this writer discussed self care goals. Client and this writer went on a walk outdoors and discussed the benefits of walking in nature. This writer spoke about the benefits regarding her own mental health recovery process that she has experienced in walking in nature. Client and this writer reviewed and revised past SMART goals. Client and this writer made 3 SMART goals about spiritual, mental, and physical health for the upcoming week.
- **Assessment**: Client seemed invested in practicing self care as evidenced by her ability to create small and achievable goals. Client seemed willing to discuss all presented topics and participate in all presented activities.
- **Plan**: This writer will talk with client's new counselor about client's progress in goals.

- **What are the key elements of the progress note present?**

Medical Necessity; Intervention; Individual Voice; Individual Response; Objective/Link to ISP; Progress; Plan/Next Steps

Example 8:

Date : 9/27/2016	**Start time: 4:00 p.m.**
Location: Shelter	**Duration**: 20 minutes
Provider type: Peer Specialist	**Code**: H0038 – Self Help Peer Support

Progress note:

- **Description**: Client is a nine year old boy who has anger issues. Client has a very hard time communicating. Client has started school at a new school and so far this year there have not been any calls from the teacher regarding his behavior. Client is making his appointments with his counselor and participating in Kids Club on a daily basis.
- **Assessment**: Client attended Kids club at the shelter. Client was there with his two other brothers and on his check in stated he felt happy and excited. Client interacted with his brothers and peers with ease. He took turns sharing and paying attention as well as followed along with the lessons.
- **Plan:** Continue to engage client in healthy activities that allow him to better communicate so he does not get frustrated and angry.
- **Personal peer experience utilized**: Having to take turns isn't always fun But sharing is showing we care.

- **What are the key elements of the progress note present?**

Medical Necessity; Intervention; Individual Voice; Individual Response; Objective/Link to ISP; Progress; Plan/Next Steps

Example 9:

Date : 9/16/2016	**Start time: 6:30 a.m.**
Location: Office	**Duration**: 30 minutes
Provider type: 21 – CDPt (20-signed of by CDP)	**Code**: H0020

- **Progress note**:

Problem: The patient wants to develop a support system to facilitate abstinence and long term recovery from drug use.

IPS Goal discussed during session today: Housing

Patient denies use. Patient shared she has had the best week ever, because she was able to ride to the clinic along. Spent most the session trying to complete the housing paperwork from HARPS. Patient understands that this may not work however is worth the time if it helps to obtain Medicaid.

Patient appears to be in the action stage of change as evidenced by her trying to find solutions to help with her socializing.

Counselor provided active listening and clarifying

Plan: Counselor will complete paperwork to fax to HARPS. Patient will continue to identify ways to meet people who don't use.

- **What are the key elements of the progress note presented?**

Medical Necessity; Intervention; Individual Voice; Individual Response; Objective/Link to ISP; Progress; Plan/Next Steps

Amending and Appending Documentation

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Behavioral Health Organizations and Behavioral Health Agencies should have a policy that outlines how amending and appending documentation can be completed that include:

- When and how to add and modify documentation
- Must be dated
- Indicate who made the modification
- What the modification included
- Reason for the modification

Amending and Appending Documentation

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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, bears the current date of that entry and is signed by the person making the addition or change.

Noridian Health Solutions 2016

Amending and Appending Documentation - Late Entry

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

Example: A late entry following supervision review of a note might add additional information about the service provide *"The services was provided in the families home with the mother (Jane Doe) and father (Jon Doe) present. Marc Dollinger, LISCW, MD 06/15/09"*

Noridian Health Solutions 2016

Amending and Appending Documentation - Addendum

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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.

- Would typically be used with an E&M code to input additional clinical or medical information, such as lab results.

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Amending and Appending Documentation - Correction

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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, making reference back 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, time, reason for the change and initials of 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.

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What to do if you have questions

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- Clinicians should discuss questions with their supervisors
- Supervisors should discuss with their BHA Quality Managers
- BHA quality managers should discuss with the BHO Quality Manager
- BHO quality manager can email the SERI workgroup: cpt-seriinquiries@dshs.wa.gov

Questions?

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Remember:

It is the Practitioner's responsibility to ensure that medical necessity is firmly established and that The Golden Threat is easy to follow within your documentation.

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References

- Noridian Health Solutions 2016
- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/documentation-matters.html
- ValueOptions-Innovative Solutions. Better Health
- http://apps.leg.wa.gov/WAC/default.aspx?cite=388
- https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information
- CMS - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html