



Patient Healthcare Records: Documentation Requirements for Utilization Review and File Audits

Optum Health Solutions Musculoskeletal (MSK)

**Utilization Management Policy
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Policy Statement

The following are required components of patient medical record documentation:

- The reason for the encounter, i.e., presenting complaint(s).
- The patients' prior medical, familial, and social history. This includes but is not limited to accidents, surgeries, medications, illnesses, and co-morbidities.
- Systems review consistent with the nature of complaint(s) and relevant historical information.
- Pertinent reports and tests that were reviewed or ordered.
- The working diagnosis(es) must be documented and consistent with the associated findings.
- A treatment plan must be included that describes the plan of care consistent with the natural history, findings, and diagnosis of the patient.
- Contraindications to care must be listed with an explanation of their current management.
- All entries to the daily medical record must be dated and authenticated. Authentication will include at least the provider's initials. In those circumstances where the provider's qualifications to render the services must be established, authentication must include the provider's full name and appropriate designation.
- File records must be organized and legible to those other than the author. When symbols or abbreviations are used, a key that explains their meaning must accompany the file.
- Records must be in chronological order and written in permanent ink.
- The documentation for each date of service must include the date, subjective complaint(s), objective findings, assessment, diagnostic impression, therapeutic intervention(s), recommendations, instructions given to the patient, and a treatment plan.
- Services must be documented in accordance with Current Procedural Terminology (CPT) coding criteria, e.g., location (body region), time component, etc.
- Each patient record must identify the patient and each page in the medical record must contain the patient's name or identification number.
- Any corrections to the patient's record must be made legibly in ink and authenticated by the person making the correction(s).
- The patient record must include periodic measures of treatment response.
- Discharge status including the current functional status, degree of goal attainment, home program given, referral or follow up, family instruction, equipment given, and reason for discharge.

The following documentation should be included in the patient's medical record:

- Each patient file should include the patient's date of birth, occupation, and appropriate contact information.
- Daily notes should be in a standard type of format, i.e., SOAP/SOP, and contain the date for return visits or a follow-up plan.
- Explicit treatment goals (functional/measurable/with a time component) should be included in chart records where the course of care is likely to extend >2 weeks.
- The patient record should include valid, reliable, and relevant outcome assessment tools, ensuring that a peer reviewer or other healthcare professionals can render a reasonable determination on the baseline status and treatment response.
- Adverse events associated with treatment should be recorded in the patient chart.

Purpose

This policy describes the elements of documentation that healthcare providers are required to include in patient medical records as well as recommended elements.

Summary

- There is a large body of evidence supporting common minimal documentation standards across physical medicine disciplines established by regulatory entities.

- Many state and national professional societies have published in-depth documents designed to inform health care providers of their ethical and legal responsibilities/risks beyond these minimum standards.
- These same documents provide templates to facilitate adherence to record keeping standards.
- Other healthcare organizations have published policies, positions, and/or reports on record keeping standards for physical medicine disciplines.
- These standards can and are applied to utilization review programs by third party payers.

Scope

This policy applies to all products and all network and non-network providers of physical medicine services where utilization review and/or file audits are conducted.

Background

Patient chart records serve as a historical account of patient/provider encounters. Record keeping is an essential component of quality-focused patient management. Good healthcare decision-making is dependent upon a practitioner's ability to retrieve accurate and complete facts from the patient's records. In addition to providing a basis for clinical decision-making, patient chart records are used to document procedures performed, patient response to care, assure for the smooth transition of care, and may be used by third-party payers as the standard to determine appropriate/necessary service utilization.

Professional licensing boards and/or state-specific statutes have established "minimal" standards/requirements for record keeping by health care professionals including chiropractors, physical and occupational therapists.

- Common elements cited by these regulations include:
 - Date (of each entry)
 - Legibility (possible to read and decipher)
 - Interpretable (by third parties, e.g., other health care providers, payers)
 - Timeliness (recorded at the time of each visit)
 - Patient demographic information
 - Problem list (symptoms/conditions)
 - Patient histories (personal, family)
 - Examination/evaluation/re-evaluation findings
 - Diagnosis/assessment (including working diagnoses)
 - Plan of care (interventions, self-care, goals)
 - Response to treatment (outcomes assessment)
 - Written reports and correspondence (sent and received)
 - Authentication (identification of the chart note author)

Regulatory standards typically apply to all licensed professionals during the normal course of care independent of remuneration, i.e., regardless of whether the fee for services was charged, reduced, or waived by means of advertisement or otherwise.

In addition to commonly sourced minimum record keeping standards, several regulatory oversight entities have described these elements in detail. Similarly, professional organizations have developed more expansive documentation standards and/or recommendations. These manuals typically provide an evidence basis supporting the consistency, content, and quality of record keeping, as well as offering templated formats.

Other health care organizations and authoritative sources have rendered commentary, reports, and/or enunciated positions/policies concerning standards for record keeping. While some of these reports and texts focus upon deficiencies in record keeping, they all describe similar minimum documentation standards. In addition to these topics, some organizations have established policies or positions that impact utilization review and file audits, i.e., services billed should be described in the patient chart in accordance with Current Procedural Terminology (CPT) coding

criteria. Billed services, which are not documented in the patient health care record, are not eligible for reimbursement.

Details of documentation, in particular time-based codes, follow Medicare guidelines. For example, when documenting minutes of time-based codes in a daily encounter note the following table will help guide the appropriate billing:

Time of procedure	Number of CPT time-based codes
Minute 8 through minute 22	1
Minute 23 through minute 37	2
Minute 38 through minute 52	3
Minute 53 through minute 67	4
Minute 68 through minute 82	5
Minute 83 through minute 97	6
Minute 98 through minute 112	7
Minute 113 through minute 127	8

Below are some examples of appropriate billing scenarios:

- 24 minutes of neuromuscular reeducation, code 97112, 23 minutes of therapeutic exercise, code 97110. Total timed code treatment time was 47 minutes. The 47 minutes falls within the range for 3 units = 38 through 52 minutes. Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time (24 minutes vs. 23 minutes).
- 20 minutes of neuromuscular reeducation, code 97112, 20 minutes therapeutic exercise, code 97110. Total timed code minutes was 40 minutes. Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other code for 1 unit. Do not bill 3 units for either one of the codes.
- 33 minutes of therapeutic exercise, code 97110, 7 minutes of manual therapy, code 97140. Total timed minutes was 40 minutes. Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

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Review and Approval History

Date	Description
07/31/2008	Original effective date
01/15/2009	Policy reformatted
04/30/2009	Annual review and approval completed
04/08/2010	Annual review and approval completed
10/26/2010	Policy rebranded to "OptumHealth Care Solutions, Inc. (OptumHealth)"
04/07/2011	Annual review and approval completed
04/19/2012	Annual review and approval completed
04/18/2013	Annual review and approval completed
04/17/2014	Annual review and approval completed; Policy rebranded "Optum*" by OptumHealth Care Solutions, Inc."
04/16/2015	Annual review and approval completed
04/21/2016	References updated; Annual review and approval completed
04/20/2017	Annual review and approval completed; References updated; Legal entity name changed from "OptumHealth Care Solutions, Inc." to "OptumHealth Care Solutions, LLC."
04/26/2018	Annual review and approval completed
04/25/2019	Annual review and approval completed
04/23/2020	Annual review and approval completed
04/22/2021	Annual review and approval completed
05/03/2022	Annual review and approval completed
06/29/2022	Updated legal entity name "OptumHealth Care Solutions, LLC." to *Optum™ Physical Health ("Optum") includes OptumHealth Care Solutions, LLC; ACN Group IPA of New York, Inc.; ACN Group IPA of California, Inc. d/b/a OptumHealth Physical Health of California; Managed Physical Network, Inc.; and OrthoNet Holdings, Inc. which includes OrthoNet New York IPA, Inc., OrthoNet West, Inc., OrthoNet, LLC, OrthoNet of the South, Inc.
04/27/2023	Annual review and approval completed; no significant changes made to the document. Updated contact email from policy.inquiry@optumhealth.com to phpolicy_inquiry@optum.com.
01/10/2024	Annual review completed. Document content transitioned to new policy template. Added time-based rule from Medicare Claims Processing Manual. Approved by Optum Clinical Guideline Advisory Committee.
04/25/2024	Annual review and approval by Optum Quality Improvement Committee.
10/09/2024	Annual review completed with no significant changes. Approved by Optum Clinical Guideline Advisory Committee.
04/24/2025	Approved by Optum Quality Improvement Committee.