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Clinical

Documentation
Guidelines

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Providers should submit adequate documentation to ensure that claims are supported as billed. For more information, please refer to Complying With Medical Record Documentation Requirements Fact Sheet (PDF) and the CERT Outreach & Education Task Forces

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webpage.

Medical Records Documentation | CMS

Providers are responsible for documenting each patient encounter completely, accurately, and on time. Because providers rely on documentation to communicate important patient information, incomplete and

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inaccurate
documentation can
result in unintended
and even dangerous
patient outcomes.

Documentation Matters Toolkit | CMS

The Medicare Program
Integrity Manual,
Chapter 3, Section
3.2.3.3, “Third-Party
Additional
Documentation
Request” states: The
treating physician,

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another clinician,
provider, or supplier

should submit the
requested.

documentation.

However, because the
provider selected for
review is the one
whose payment.

Complying With Medical Record Documentation Requirements

February 16, 2018 -
The American College
of Physicians (ACP)

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recently applauded a
CMS decision to
change EHR clinical
documentation
requirements.

Teaching physicians
can now verify medical
student ...

CMS Modifies E/M EHR Clinical Documentation Requirements

As part of our Patients
over Paperwork
Initiative, Medicare is
simplifying

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documentation requirements so that you spend less time on paperwork, allowing you to focus more on your patients and less on confusing and time-consuming claims documentation. We've made some important changes already. We need your suggestions on where to focus next.

Simplifying Documentation Requirements | CMS

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Electronic Clinical
Quality Measures
(eCQM) Requirements
For 2020 eCQM
requirements, CMS has
reduced the number of
eCQMs available from
16 to eight.

Participants must
report on four eCQMs.
The reporting period
has also been changed
to a self-selected
calendar quarter of
2019. More information
can be found on the
CQMs Basics page.

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Hardship ...

2020 Program Requirements Medicare | CMS

Document in appropriate office records and/or hospital records each time a covered Medicare service is provided. When providing concurrent care for hospital or custodial care facility patients, physicians should identify his/her... Write

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medical information
legibly and sign each
entry with a legible ...

Documentation Guidelines for Medicare Services - JE Part B ...

A federal government
website managed and
paid for by the U.S.
Centers for Medicare &
Medicaid Services.

7500 Security
Boulevard, Baltimore,
MD 21244 CMS & HHS
Websites [CMS Global

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Footer] Medicare.gov

ICN006764 | CMS

CMS Administrator
Announces Proposal to
Spur Innovation for
America's Seniors,
Participates in
Roundtable Discussion
Among Health Industry
Leaders in Minneapolis
Home A federal
government website
managed and paid for
by the U.S. Centers for
Medicare & Medicaid
Services. 7500 Security

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Boulevard, Baltimore,
MD 21244

Regulations & Guidance | CMS

CMS indicates that the use of both is certainly allowed within documentation.

Additionally, there is an additional resource available from CMS, titled the Program Integrity Issues in Electronic Health Records. CMS indicates the following regarding

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the use of both
techniques:

Copying and Pasting: The Real Rules Prevail - RACmonitor

They may include: If the dosage for the drug under review is outside the allowed amount per the drug compendium, submit documentation to support the medical necessity of this dose variance (i.e. Clinical

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trial, article, studies,
etc.) Multiple CMS

contractors are
charged with
completing reviews of
medical records.

Drugs, Biologicals and Injections Documentation ... - Medicare

fraud. We also
reviewed guidance
documents and policies
on EHRs and fraud
vulnerabilities that
CMS and its

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contractors released for health care providers. Lastly, we reviewed documents on EHRs and Medicare claims that CMS provided to its contractors. WHAT WE FOUND . CMS and its contractors had adopted few program integrity practices specific to ...

**Department of
Health and Human
Services**

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Check. Documentation
Requirements.

Documentation is for
the correct beneficiary.

Documentation
contains a valid and
legible signature.

Documentation clearly
identifies the person
performing the service
(including title,
education background,
credentials)

Documentation clearly
demonstrates session
start and stop times
and/or total time spent

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providing
psychotherapy services
to the beneficiary.

Checklist: Psychotherapy Services Documentation

CMS information about
the MIPS Improvement
Activity for
participation in a
COVID-19 clinical trial.
CMS resource provides
additional guidance to
physicians. In an MLN
matters article (PDF),

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... obtaining new order from a physician and new medical necessity documentation. CMS guidance:

CMS payment policies & regulatory flexibilities during ...

CMS requires that a qualified healthcare provider identify all chronic conditions and severe diagnoses for each patient, to substantiate a “base year” health profile for

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those individuals.

Documentation in the medical record must support the presence of the condition and indicate the provider's assessment and plan for management of the condition.

Medicare Risk Adjustment & HCC Clinical Documentation ...

CMS made two changes to E/M documentation and

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coding effective
January 1, 2019: 1. The
physician/non-
physician practitioner
will no longer be
required to document
the medical necessity
of a home care visit
versus an office visit.
Documenting the
medical necessity for a
visit, regardless of
patient location,
remains a requirement
for payment.

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Documentation **Coding Handbook: Palliative Care**

Clinical practice guidelines are resources* for Humana-contracted physicians and other Humana-contracted healthcare professionals. Humana has adopted the following guidelines:
Adult immunizations.
Centers for Disease Control and Prevention (CDC) Recommended immunization schedule for adults aged 19

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years or older, United States 2020.

Clinical Practice Guidelines for Healthcare Providers - Humana

LCDs are coverage guidelines developed by the local Medicare Administrative Contractor (MAC) to provide rules either for determination of coverage in absence of a national policy or for further clarification of a

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national policy.

Providers should be aware of LCDs published by their local contractor. Locate a current LCD on the CMS Web site

Medicare Coverage Policies: Speech-Language Pathology

ADDENDUM ITEMS

- Hospital documentation present in the clinical record shall validate response(s) where

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Documentation Outcomes

appropriate on the MDS 3.0 that reflects the resident's hospital stay prior to admission, if the dates are within the observation period that ends on the ARD date. • The ARD date is the last day of the MDS observation period.

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