TurningPoint
Healthcare Solutions

TURNINGPOINT CLINICAL POLICY

Last Modified: 2/11/2021

Policy Number: GN-1002
Policy Name: Medical Record Documentation

Definition: To ensure receipt of best available care, medical records should contain accurate and thorough documentation. TurningPoint will accept documentation as outlined in this policy to promote consistency and standardization.

I. **Policy statement:**
Acceptable medical records must meet all of the following: All!!??

A. Pre-operative documentation/Office visit notes
   1. Signature: Each entry should include the author and appropriate signature with date. Surgical candidates should be seen by the surgeon within 30 days prior to surgery, at which time decision for surgery should be made and documented.
      a. Established patients with a prior history and physical exam documented can have either a telemedicine or in-person visit within 3 months prior to surgery
      b. New patients should have an in-person visit within 3 months prior to surgery; decision for surgery can be made at this visit or at a later telemedicine visit if need be
      c. For both of the above scenarios in a. and b., if the visit is outside 30 days prior to surgery (but within 3 months), documentation should be included to notate the pre-op visit date; the pre-op visit notes are not required to be submitted
   2. Clean: Notes should be submitted in chronological order, with margins free from writing. Incorrect documentation should not be crossed or whited out; corrections should be made and submitted as new entries with appropriate signature and date.
   3. Legibility: If handwritten, records must be legible to someone other than the author. Unacceptable faxed information includes documentation that cannot be read because it is illegible, too light or too dark, or obscured by artifact.
   4. Identification: Patient's name or ID number should be on each page.
   5. Patient-specific: Documentation that is identical to other medical records submitted (cloned documenting) will not be accepted.
   6. Clinical documentation: Must include thorough and detailed history of current problem and physical examination; most recent smoking status and BMI must also be documented. Should also include medical history, medication list, allergies and drug reactions, family history, surgical history, and social history including substance use. Comorbidities should be addressed as appropriate; clear documentation of risks versus benefits must be included.
   7. Non-operative treatment: Attempted treatments must be clearly documented in the medical record and include specific type, frequency, duration, and response for each; must also include details on who prescribed the treatment. These may include any combination of the following (see specific medical policies for further details):
      a. Medication (anti-inflammatories, analgesics)
      b. Physical therapy

Clean?? what??

ours don't. Have "page 3 of 4"

what records with ERR is completely devoid of some copied text?

So, lack of info on subst abuse is grounds for denial, apparently

more reasons for denials

i. Must include notes from physical therapist; should include initial and final visits. — who has these??
ii. Detailed home exercise program may be accepted if completed in place of PT. This should be instructed by a physical therapist, athletic trainer, PA, or MD/DO. — How to document? I have exercises on my site, drwolgin.com

Note: For total and partial knee replacements, an initial physical therapy visit will be accepted. A home exercise plan or joint class with documentation of date instructed, along with which exercises were prescribed and by whom, will also be accepted.

c. Weight loss
   i. BMI of 30-35 requires weight loss discussion; must see documentation of discussion between provider and patient (e.g. maintaining healthy weight, acceptable BMI, lifestyle modifications, etc.).
   ii. BMI of 35-40 requires documented weight loss plan (e.g. patient joining Weight Watchers, reducing caloric intake, increasing exercise, meal planning, seeing nutrition specialist, etc.).
   iii. BMI greater than 40 requires documented weight loss on a case-by-case basis.
d. Injections
e. Assistive devices (e.g. crutches, cane, brace, splint, orthotics)
f. Thermal or cryotherapy
g. Activity modification
   i. Detailed examples should be given to show how the patient's pain interferes with their daily activities. — How detailed? Notes indic can't do their ADL's
h. Systemic therapy (e.g. medication for rheumatoid arthritis, chemotherapy)
i. Psychological and/or behavioral therapy — on whom?

8. Imaging: Must submit imaging reports for imaging done out of office. If surgeon's and radiologist's interpretations of imaging differ, addendums to the radiology report will be requested for clarification. Objective documentation from surgeon for x-rays taken and read in-house is acceptable. → Not requested. These discrepancies used as reasons for denials.
9. Treatment plan: Clear and detailed documentation of the surgical plan and rationale from the surgeon, including all procedures to be performed and specific anatomical locations. Plan should be consistent with patient's diagnosis; medical work up should be thorough and rule out other etiologies.
   a. The surgical plan should include rationale for and align with all procedure codes requested. Codes with CCI edits may be denied unless the medical record contains documentation to support separate requests.
   b. Procedures that are "possible" will not be authorized without evidence to support medical necessity in the records submitted.

→ Another arbitrary reason for denial. Reasons for "possible" procedures is that in many cases, you don't know what you are going to do until you are in there.

as of 2/6/23, my pt DB remains not approved, despite severe spinal cord compression

Pure bad faith.

References

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Regulatory Data

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Approval Authority:	Utilization Management Committee
Business Owner:	Utilization Management
Applicable lines of business:	All
Board approval, if appropriate:	n/a
Approval Signature:	On file

URAC Standards:	
State Requirements:	
CMS/Federal Requirements:	
Corresponding policies:	