

Texas Tech University Health Sciences Center El Paso Institutional Compliance Policy

Policy: BCP EP 4.0 Basic Documentation Standards For Billing Purposes	Effective Date: December 1, 2009
	Last Revision Date: January 24, 2024
References: CMS.gov; IOM 100-04, Chapter 12, Section 100; IOM 100-08, Chapter 3, Section 3.3.2.4; TTUHSC EP SOM Ambulatory Clinic Policies and Procedures EP 5.19 - Scribes in the Clinic Setting, https://elpaso.ttuhscc.edu/opp/default.aspx	

Policy Statement

This policy sets forth basic documentation standards that apply to the billing of healthcare items or services to a patient or his/her third-party payer.

Scope

This policy applies to all Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso) Schools that bill for healthcare items and/or services under a TTUHSC El Paso’s tax identification number.

Policy

The documentation standards outlined in this policy apply to all medical records, regardless of whether they are created as paper records or electronic medical records.

Policy on Documentation Standards

1. General Concepts

- a. All providers are expected to use the electronic medical record. There should be an audit trail to verify the author of electronic entries. Electronic signatures shall comply with federal and state laws. (Center for Medicare Services (CMS) Manual Medicare Program Integrity Manual (Pub. 100-08) Chapter 3, Section 3.3.2.4.
- b. Paper records:
 - Legibility. Healthcare items or services documented in the medical record should be legible. (CMS Manual Medicare Program Integrity Manual (Pub. 100-08) Chapter 3, Section 3.3.2.4. Healthcare items or services should not be billed if 3 individuals within the provider’s department are unable to read the entry.
 - Signature and Credentials. All entries into the medical record should be signed or initialed by the individual making the entry and shall include the person’s credentials (e.g., MD, DO, CMA’s, RN’, LVN’s, CNM, etc.).

2. Scribes

In accordance with School of Medicine Ambulatory Clinic policy and procedure EP 5.19 - Scribes in the Clinic Setting, a scribe is a documentation assistant that records in “real-time,” facts, data and events that occur between a patient and a provider. The scribe enters information into the electronic medical record (EMR) or chart at the direction of the

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provider. An individual acting as a scribe shall not, in any manner, correct, interpret, clarify or otherwise enter anything other than the exact wording or directions of the provider, or patient/guardian. The scribe must not interject his/her own observations or impressions. The provider is ultimately responsible for all documentation and must verify that the scribed note accurately reflects the service provided.

3. Documentation of Health Care Items and Services

It is the responsibility of TTUHSC El Paso and its various clinical departments to implement a process so that healthcare items or services have been documented before submission of a claim for payment of those healthcare items or services. No health care items or services should be billed unless there is documentation in the medical record to support the health care item or service.

4. Evaluation and Management (E/M) Services

For billing purposes, E/M services shall be documented in accordance with CPT coding instructions, and the 2021 and 2023 Documentation Guidelines for Evaluation and Management Services (EMDG) created by the American Medical Association and adopted by the Center for Medicare and Medicaid Services. The EMDGs are located at <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf>

5. Teaching Physician Presence and Documentation

- a. Medicare Teaching Physician Rule. Unless otherwise stated in this or other written Billing Compliance Policies, (BCP) Medicare's teaching physician rules regarding teaching physician presence and documentation (42 CFR 415.170 - 415.190) apply to all payers for billing of health care items or services involving a student and or resident.
- b. Texas Medicaid Teaching Physician Rule. To the extent it does not interfere with meeting Medicare's teaching physician rules for non-Texas Medicaid payers, Texas Medicaid supervision and documentation standards for teaching physicians apply for billing of health care items or services involving a student and or resident where Texas Medicaid is the primary payer. More detailed guidance on presence and documentation required under Texas Medicaid's teaching physician rules is contained in separate Billing Compliance (BC) policies addressing teaching physician presence and documentation.
- c. Billing Compliance Policies (BCP) on Teaching Physician Presence and Documentation. Additional detailed guidance on presence and documentation required under Medicare and Texas Medicaid's teaching physician rules, including, but not limited to use of electronic macros and extent of documentation, is contained in separate BC policies addressing teaching physician presence and participation.

6. Other Documentation Standards

The patient's third-party payer may require additional documentation for billing of health care items or services that are not addressed in this or other BCP's. It is the responsibility of

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TTUHSC El Paso to make sure health care items and services are properly documented in accordance with the payer's contractual requirements and/or policies.

Administration and Interpretation, Revisions or Termination

Refer to Billing Compliance Program Policy and Procedure 1.0 Policy Development and Implementation Failure to comply with this policy shall result in appropriate disciplinary action.

Questions regarding this policy may be addressed to the TTUHSC El Paso Institutional Compliance Officer (ICO) or Billing Compliance Unit Manager.

Frequency of Review

This policy shall be reviewed no later than January in each odd-numbered year.

Review Date: December 2017, March 2019, October 1, 2021, January 24, 2024

Revision Date: June 1, 2015, January 1, 2017, March 2019, October 1, 2021, January 24, 2024