Humana Medical Record Types and Definitions

Click the medical record type to see the definition.

Activities of daily living	Consents	Extracorporeal membrane oxygenation (ECMO) flowsheets	Labor and delivery	Pharmacy dispensing records	Radiology/oncology documentation
Anesthesia records	Consultations/Evaluations	Emergency department reports	Letter/certificate of medical necessity	Physical/speech/occupational therapy notes	Referrals
Authorizations	Critical care time	Evaluation and management visit	Medication administration record with start and stop time and waste	Physician certification statement	Respiratory therapy notes
Behavioral health therapy notes	Detailed itemizations	Face-to-face documentation	Medication administration record	Physician progress notes	Social service notes
Blood transfusion records	Detailed written order	History and physical	Medication records	Plan of care	Supply list
Call log	Diagnosis notes, including past medical history	Home health care notes	Mental status exams	Prescriptions	Telephone encounters
Cardiology reports	Diagnostic results	Hospital care records	Nitric oxide flowsheets	Procedure reports	Therapy notes/grids
Case management notes	Dialysis report (dialysis flowsheet)	Implant log/Detail	Nurse notes	Proof of delivery	Treatment and administration record
Chemotherapy flow sheet	Dietary notes	Infusion administration sheet	Observation logs	Proof of receipt of the item documenting beneficiary name, and beneficiary or designee signature	Treatment plan notes
Certified nursing assistant (CNA)/home health aide (HHA) notes	Discharge planning notes	Initial psychiatric evaluation	Operative reports	Proof of receipt of the item documenting the date the item was obtained in the office or delivered	Treatment plans (initial and updated), including all therapy and progress notes for dates of service billed
Complete ambulance trip notes with mileage	Discharge records	Interventional radiology	Ophthalmologist/optometrist/eye exam	Psychiatric evaluation notes	UB-04
Complete medical records including dictated and handwritten notes	Discharge/transfer/death summary	Intraoperative report including implant detail	Orders	Psychiatrist progress notes	Waste documentation
Complete medical records for the dates of service	Drug invoice	Itemized bill	Outcome and assessment information set (OASIS)	Radiation treatment planning system including dictated and handwritten notes	Wound care consult and treatment notes
Complete medical records including clinical trial informed consent but excludes nurse's notes	Drug supplier information	Lab reports	Pathology reports	Radiology reports	

Back to top

Activities of daily living

Items needed to support Section GG (Functional Abilities and Goals Assessment) of the Medical Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) manual, and Section G (Functional Status) if isolation is coded.

Anesthesia records

Anesthesia report of procedure, detailing medication and/or monitoring performed by a qualified provider and signed by a rendering provider. Documentation includes but is not limited to: patient identifiers (name and date of birth), date of service, time in and time out, flowsheet medication given with the start and stop time. See Humana's claim payment policy on anesthesia services for more information.

Authorizations

Authorization form supporting items being provided are approved by Humana based on diagnosis and medical necessity.

Behavioral health therapy notes

Detailed notes of therapy (individual or group) performed on billed date of service. Notes should detail therapy performed, correlation to patient's plan of care and patient's participation in therapy session.

Blood transfusion records

Flowsheet that includes patient identifiers (name and date of birth), date of service, blood product administered, start and stop time of blood infusion and nursing signature.

Call log

Documentation supporting a two-way communication. Includes but not limited to: specific date and time, individual provider contact, method of contact and description of encounter.

Cardiology reports

All cardiology reports, electrocardiograms (EKGs), echocardiograms, cardiac catheterizations with patient identifiers (name and date of birth) and date of service.

Case management notes

Case management notes detailing encounter, interventions performed, time spent and date of service.

Chemotherapy flow sheet

Documentation used by oncology outpatient facilities to support the actual provision of chemotherapy. This document should include the patient's name, date of birth, date of service, name of the drug, route given, dose administered, along with the date and start and stop time of the drug administered. Also, include the initials or signature of the registered nurse (RN) who administered the drug.

Back to top

Certified nursing assistant (CNA)/home health aide (HHA) notes

Visit notes from a qualified CNA/HHA detailing the visit date, time, vital signs and personal care provided to the patient during the episode of care.

Complete ambulance trip notes with mileage

Include the ambulance run report detailing: pick up time, treatment provided and patient drop off time; a detailed statement of the condition which necessitated ambulance service; point of pick-up (identify place and complete address); destination (identify place and complete address); notes about the events that occurred during the call in chronological order and the number of miles traveled (miles the patient was in the ambulance).

Complete medical records including all dictated and handwritten notes

Complete medical records include all records for the patient for the specific date(s) of service indicated on the medical record request. This includes, but is not limited to (dictated and handwritten): all clinical documentation, all physician notes, emergency department notes and reports, history and physical, discharge summary or transfer notes, procedure notes, operative reports, anesthesia records, consultations, dietician notes, progress notes related to the services provided, imaging reports and results, laboratory and pathology reports and results, medication administration records, nurse's notes, therapy notes or any other specific reports noted on the record request.

Complete medical records for the dates of service

The same records as listed above for the patient for the specific date(s) of service indicated on the medical record request.

Complete medical records including clinical trial informed consent but excludes nurse’s notes

Standard of care (SOC), plan of care (POC), informed consent, clinical trial signature form, clinical trial identification number and current clinical trial cycle.

Consents

Documentation supporting written or verbal consent was obtained. Documentation including description of service with signed and dated patient consent.

Consultations/Evaluations

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate sources. Documentation of investigation or inspection of a patient for the purpose of diagnosis, prognosis, and treatment; specific for skilled nursing facility (SNF) review request and may include a look back period ({assessment reference date} minus 6 days or {assessment reference date} minus 59 days for establishing an active or current diagnosis).

Back to top

Critical care time
Critical care is a time-based service. Time may be continuous or an aggregate of intermittent time spent by patients of the same group and same specialty. Progress notes must document the total time critical care services were provided for each date and encounter entry.

Detailed itemizations
Breakdown of all charges on a claim for each revenue code billed, description of all charges, credited items, total amount charged and prices of each item listed in the medical record as utilized. Units on itemized bill (IB) must match claim units.

Detailed written order
A detailed written order (DWO) is a document used to authorize what was ordered by a patient's treating or prescribing physician. Detailed written orders must include all billable items, accessories or supplies related to the base item that is ordered. Document must be signed and dated by ordering physician.

Diagnosis notes including past medical history
Signed physician documentation with the patient’s treating diagnoses, as well as the past medical history of the patient. These can be provided through the hospital or rehabilitation facility documentation, as well as the physician's office.

Diagnostic results
Documentation of all test results; examples include, but are not limited to: imaging, X-ray and labs.

Dialysis report (dialysis flowsheet)
Flowsheet that includes patient identifiers (name and date of birth), date of service, start and stop of dialysis, nurse’s signature and any medication given during treatment.

Dietary notes
Any notes or assessments conducted by a registered dietician during the look back period ({assessment reference date} minus 6 days or {assessment reference date} minus 59 days for establishing an active or current diagnosis).

Discharge planning notes
Discharge documentation signed by the physician from the hospital or rehabilitation facility from which the patient was discharged. These would include the reason for hospitalization with a description of the patient’s primary presenting condition, significant findings, procedures and treatment provided, patient’s discharge condition, along with patient and family instructions.

Back to top

Discharge records

Signed physician documentation from the hospital or rehabilitation facility providing information about where the patient is being discharged to along with the types of care the patient will require, such as home health services and who will be providing that care.

Discharge/transfer/death summary

Documentation supporting specific date and time of event and/or disposition with appropriate patient identifiers (name and date of birth).

Drug invoice

A drug invoice includes the amount the physician's office paid for the drug (indicated on the invoice submitted to the office) for the specific drug used for a patient. A drug invoice will include the name of the physician or facility, invoice date, name of drug and the amount or number of vials received.

Drug supplier information

A drug supplier is a licensed retail pharmacy which supplies drugs to licensed prescribers for their office's administration and/or supplies drugs to hospitals and other licensed pharmacies for their dispensing. This document would include the pharmacy name, provider name, drug name and number of vials or doses dispensed.

Extracorporeal membrane oxygenation (ECMO) flowsheets

Flowsheet includes patient identification number, date of service and documentation for dates of service ECMO is billed.

Emergency department reports

Emergency department records are specific to all medical or nursing care rendered and the patient's response to that care during their emergency room (ER) visit. Documentation of the ER service should clearly identify services were rendered in the emergency department. If the patient is admitted into observation, the documentation must clearly demonstrate the patient has been admitted to the observation unit. Documentation should include but is not limited to: time of arrival, event summary including medications, labs, testing, and time and place of disposition (e.g. telephone, observation, inpatient).

Evaluation and management visit

Evaluation and management (E/M) visits are cognitive (as opposed to procedural) services in which a physician or other qualified healthcare professional diagnoses and treats illness or injury. E/M codes can also include preventive services/medicine. Within the preventive care documentation, it should include the following: screening services, advanced care planning, Annual Wellness Visit, discussion of risk factors and ability to perform daily living activities (to measure the capability to remain independent in their home).

Back to top

Face-to-face documentation

Specific to home health reviews, the documentation must include the date when the patient was seen by the physician or nonphysician practitioner (NPP) and a brief narrative composed by the certifying physician describing the patient's clinical condition during the encounter which supports the patient's homebound status and need for skilled services. The face-to-face encounter must occur within 90 days prior to the start of home healthcare or within the 30 days after the start of care.

History and physical

Documentation, signed by a physician, addressing the patient's chief complaint, details of present illness, relevant history appropriate to the patient's age, medication, allergies, assessment of body systems, conclusion or impression and plan of care relevant to the patient.

Home health care notes

Individual visit notes written by any and all disciplines providing care to the patient under home health services. Each visit's notes must contain but are not limited to: visit date, units billed for visit, signature of clinician, credentials of clinician and homebound status.

Hospital care records

All available records for the patient for the dates of service indicated on request.

Implant log/Detail

Implant log detail that **must** include the following information: item name, identifying number (catalog, serial, model, reference, sticker, re-ordering number, whatever the manufacturer uses to register with the FDA) and total units implanted.

Infusion administration sheet

The infusion administration sheet is a document used in a physician's office or outpatient facility. This document should include the patient's name and date of birth, date of service, the name of the drug, dose administered, route, date and time drug administered (start and stop times) and the amount of drug waste. Also, include the initials or signature of the registered nurse who administered the drug.

Initial psychiatric evaluation

First completed psychiatric evaluation, including the date of service and provider's signature and credentials.

Interventional radiology

All interventional radiology procedure(s) completed during an episode of care.

Back to top

Intraoperative report including implant detail

Documentation supporting segment of the surgical procedure performed. Includes but is not limited to: patient identifiers (name and date of birth), dates of service, procedure performed, in/out times for segments of surgery/procedures, anesthesia and recovery room, implants used during surgery and signatures of staff performing services.

Itemized bill

The detailed itemization (also referred to as the itemized bill) is a detailed breakdown of all charges, line by line, including revenue codes when appropriate, CPT or HCPCS code(s) (to identify what services were provided), item description, units billed and charges for each line item.

Lab reports

Details of laboratory tests performed and the results of those tests. Documentation of results should include but are not limited to: patient identifiers (name and date of birth), date of service, number of units, methodology used and any special testing services that are necessary. Results need to be the original results form or documentation received. Re-typed or handwritten results are not considered original results.

Labor and delivery

Documentation identifying but not limited to: patient identifiers (name and date of birth), date of service, type of labor and delivery service billed, start and stop or in and out times of delivery and active labor, and signatures of staff providing services.

Letter/certificate of medical necessity

Letter or certificate from the ordering provider that substantiates the medical necessity of services or equipment billed.

Medication administration record with start and stop time and waste

A medication administration record (MAR), also referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a patient by a healthcare professional. A MAR should include the patient's name and date of birth, date of service, medication name, dose administered, route, exact time the medication was given, duration, exact stop time of administration, any waste appropriately disposed and the initials of nurse or provider who administered the medication.

Medication administration record

A medication administration record (MAR), also referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a patient at a facility by a healthcare professional. A MAR should include patient's name and date of birth, date of service, medication name, dose administered, route, exact time the medication was given, duration, exact stop time of administration, any waste appropriately disposed, and initials of nurse or provider who administered the medication.

Back to top

Medication records

A medication administration record (MAR), also referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a patient at a facility by a healthcare professional. A MAR should include patient's name and date of birth, date of service, medication name, dose administered, route, exact time the medication was given, duration, exact stop time of administration, any waste appropriately disposed, and initials of nurse or provider who administered the medication.

Mental status exams

Refer to The Brief Interview for Mental Status and The Physician's Assistant Health Questionnaire, V9. (See Chapter 3 of the CMS Resident Assessment Instrument Manual). Documentation must include patient identifiers (name and date of birth), date of service, and signature and credentials of individual rendering exam.

Nitric oxide flowsheets

Flowsheet includes patient identifiers (name and date of birth), date of service, nitric oxide documentation, start and stop time of nitric oxide.

Nurse notes

Individualized visit notes completed and signed by a qualified registered nurse (RN) or licensed practical nurse (LPN) detailing the date of visit, time of visit, vital signs, comprehensive assessment, interventions or procedures performed and narrative of all teaching and services performed. These should support the plan of care (CMS 485 [formerly HCFA-485] form) and include accurate and specific descriptions of the visit performed.

Observation logs

Documentation supporting observation services that includes but is not limited to: patient identifiers (name and date of birth), time of arrival, event summary including medications, labs, tests and services provided, time of departure, start and stop time for all infusion medications, and time of all non-infusion medications, along with signature of the person administering the medication.

Operative reports

Surgeon operative report detailing the procedure. The operative report captures what transpired in the operating room. It must support the medical necessity for treating the patient, describe each part of the surgical procedure(s), and reveal the results of the surgery. This document includes the following but is not limited to: patient identifiers (name and date of birth), date of service, name of procedure performed, implant used and how many, specific diagnosis codes, timeframe of sedation and signature and credential of the surgeon.

Ophthalmologist/optometrist/eye exam

Documentation supporting a comprehensive list of tests performed by an ophthalmologist or optometrist. Documentation includes the following but is not limited to: patient identifiers (name and date of birth), date of service and narrative of exam with results.

Back to top

Orders

Documentation supporting specific orders from healthcare providers. Documentation should include but is not limited to: patient identifiers (name and date of birth), date of service, specific service/treatment/item/medication being ordered, signature and credentials of provider.

Outcome and assessment information set (OASIS)

The OASIS is a patient-specific, standardized assessment used in Medicare home healthcare to plan care, determine reimbursement and measure quality. It is a comprehensive assessment and designed to collect information on nearly 100 items related to a home care recipient's demographic information, clinical status, functional status and service needs. The OASIS is completed upon admission, discharge, transfer and change in condition for all Medicare beneficiaries. OASIS data is collected by a home care clinician (e.g., nurse or therapist) via direct observation and interview of the care recipient and/or caregiver.

Pathology reports

Details of pathology tests performed and the results of those tests. Documentation of results should include but are not limited to: patient identifiers (name and date of birth), date of service, number of units, and any other special testing services completed. Results need to be the original results form or documentation received. Re-typed or handwritten results are not considered original results.

Pharmacy dispensing records

Pharmacy dispensing records are legal documents that provide the drug dispensed to and administered by the physician office or outpatient facility. This document should contain: patient's name and date of birth, provider or facility name and address. It should provide the name of the drug, amount of drug dispensed or number of vials used or dispensed, route and date range of administration. Additionally, the patient's diagnosis and the drug's NDC number may be required.

Physical/speech/occupational therapy notes

Documentation supporting physical therapy (PT), speech language pathology or speech therapy (ST) and/or occupational therapy (OT) notes rendered by a qualified therapist. Documentation should include both initial evaluations and re-evaluations. Note: For skilled nursing facility patients, these should include the lookback period ({assessment reference date} minus 6 days or {assessment reference date} minus 59 days for establishing an active or current diagnosis). Documentation should include but is not limited to: patient identifiers (name and date of birth), date of service, direct 1x1 therapy notes, in and out times, units billed for each treatment, type of therapy/modality performed, comprehensive assessment, interventions or procedures performed, narrative of all teaching and modalities performed and specific muscles targeted (if PT).

Physician certification statement

The physician certification statement (PCS) is a document supporting the need for ambulance transport. This document should detail the need for ambulance transport and must include the signature and credentials of the ordering provider.

Back to top

Physician progress notes

Physician progress notes represent a patient's interval status during a hospitalization or an outpatient visit or treatment with a post-acute care provider or other healthcare encounter. Documentation should include but is not limited to: patient identifiers (name and date of birth), date of service, diagnosis, physician findings, plan of treatment and signature and credentials of provider rendering the service.

Plan of care

Plan of care is a written document developed for each individual by the support team using a person-centered approach that describes the support, services and resources provided or accessed to address the needs of the individual. Documentation should include but is not limited to: patient identifiers (name and date of birth), date of service, all pertinent known diagnoses (patient's mental, psychosocial, and cognitive status), the types of services, supplies and equipment required, the frequency and duration of visits required, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury, description of the patient's risk for emergency department visits and hospital readmission and all necessary interventions to address the underlying risk factors. Patient and caregiver education and training to facilitate timely discharge should include: patient-specific interventions and education, measurable outcomes and goals identified by the home health aide and the patient, information related to any advanced directives, and any additional items the home health aide or physician may choose to include. This must be signed and dated by the physician as well as all discipline(s) performing services.

Prescriptions

A prescription is a legal document that provides the patient's name and date of birth, date of service, name of drug or durable medical equipment (DME) item, dose to administer, route, number of doses to be dispensed and physician signature with credentials.

Procedure reports

Procedure reports, also called procedure notes, is a broad term that encompasses many specific types of non-operative procedures. The procedure report documents the indications for the procedure and, when applicable, post-procedure diagnosis, pertinent events of the procedure, and the patient's tolerance of the procedure. If applicable, the report should include the wound measurements, type of product used, amount used and amount wasted. Humana uses the procedure report to verify that the documentation supports all codes reported on the claim. Note: The procedure note can be documented in the body of the E/M document. Unlike the operative report, the provider is not required to submit a separate procedure report.

Proof of delivery

Documentation that substantiates delivery of medical equipment. Proof of delivery (POD) is a document that is signed by the consignee (receiver) of a shipment that confirms that a shipment has arrived, with all the items accounted for and with no visible damage. Humana requires suppliers to maintain complete and accurate POD documentation, consistent with the standards of Chapter 4, Section 4.26 and Chapter 5, Section 5.8 of the

Back to top

Medicare Program Integrity Manual. Refer to Humana's Claims Payment Policy – DMEPOS Proof of Delivery Documentation for more details. An example of POD to a beneficiary is having a signed delivery slip, and it is recommended that the delivery slip include: 1) the patient's name; 2) the quantity delivered; 3) a detailed description of the item being delivered; 4) the brand name; and 5) the serial number. For example, a detailed HCPCS code description may be used to provide a detailed description of the item being delivered; though suppliers are encouraged to include as much information as necessary to adequately describe the delivered item. The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply shall be the date of service on the claim. If the supplier utilizes a shipping service or mail order, an example of proof of delivery would include the service's tracking slip, and the supplier's own shipping invoice. If possible, the supplier's records should also include the delivery service's package identification number for that package sent to the beneficiary. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and if possible, the date delivered. If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim.

Proof of receipt of the item documenting beneficiary name, and beneficiary or designee signature

Documentation that supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is required to maintain. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary. Documentation must support a sufficient, detailed description to identify the item(s) being delivered (e.g., brand name, serial number and narrative description). This includes items picked up or given to a patient in an office setting.

Proof of receipt of the item documenting the date the item was obtained in the office or delivered

Documentation that a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is required to maintain. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary. Documentation must support sufficient detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description). This includes items picked up or given to a patient in an office setting.

Psychiatric evaluation notes

Documentation containing details of a psychological or psychiatric evaluation performed by a psychologist or physician. Documentation must include the rendering provider's signature and credentials.

Back to top

Psychiatrist progress notes

Documentation containing details of a psychological or psychiatric evaluation performed by a psychologist or physician. Progress notes represents a patient's interval status during a hospitalization, outpatient visit, treatment with a post-acute care provider or other healthcare encounter. Documentation should include, but is not limited to: Patient identifiers (name and date of birth), date of service, diagnosis, physician findings, plan of treatment and the signature and credentials of the provider rendering the service.

Radiation treatment planning system including dictated and handwritten notes

Documentation to support the actual provision of radiation treatment to include, but not limited to: history of illness being treated (active/current diagnosis), history of physician involvement and supporting clinical documentation for all services billed: physician order(s) for treatment that includes prescribed dosage and technique, as well as completed dosimetry plans and reports, physicist reports, simulation reports, oncology reports, physician procedure reports, documentation of each treatment delivered (planning technique, number of treatments prescribed, number of ports/fields, devices used, dose delivered, cumulative dose achieved), radiological reports or physician interpretations and any contrast provided. When appropriate include the lookback period ({assessment reference date} minus 6 days or {assessment reference date} minus 59 days for establishing an active or current diagnosis).

Radiology reports

The radiology report represents the sum of a radiologist's highest level of synthesis and insight into a patient's condition and is the most important way that radiologists contribute to patient care. The report should communicate relevant information about diagnosis, condition, response to therapy, and/or results of a procedure performed, all imaging completed during an episode of care and answer any clinical questions raised by the requesting patient-care provider that is relevant to the radiologic study.

Radiology/oncology documentation

Documentation to support the actual provision of radiation treatment within the lookback period ({assessment reference date} minus 6 days or {assessment reference date} minus 59 days for establishing an active or current diagnosis) and needs to support when radiation was actually administered (dose, number of radiation treatments, greys, reports, etc.). Documentation to include, but not limited to: a detailed itemization and supporting documentation for all services billed, history of illness being treated, history of physician involvement, physician order(s) for treatment that includes current dosage, proof all services billed were provided (dosimetry reports, physicist reports, simulation reports and oncology reports), each treatment billed, copy of radiological report or physician's interpretation and any contrast material provided.

Referrals

Documentation supporting relevant clinical information about the patient's condition for investigation, opinion, treatment and management, date of the referral and signature of the referring practitioner. Also note: Home health services referral documentation needs to include all pertinent diagnoses to support a patient's homebound status and their need for skilled service.

Back to top

Respiratory therapy notes

Documentation supporting all respiratory therapy rendered by a qualified practitioner (e.g., respiratory therapists, physical therapists, nurses and other qualified personnel). Documentation to include, but not limited to: Ventilator, tracheostomy and respiratory services, oxygen provided, metered dose inhaler (MDI)/Nebulizer treatments, pulse oximetry, arterial punctures, chest physiotherapy, suctioning, tracheostomy care, tracheostomy changes, intubation and extubating.

Social service notes

Documentation supporting the specific social services billed were rendered. Documentation to include, but not limited to: patient identifiers (name and date of birth), date of service, where and how services were rendered (e.g., clinic, office, home, phone), interventions, skills training, intended goal(s), outcome related to the intervention or skills training services and signature and credentials of individual rendering services.

Supply list

List of all supplies provided on the itemized bill with dates of service.

Telephone encounters

Documentation supporting a service rendered via telephone to include but not limited to: patient identifiers (name and date of birth), date of service, detail of encounter and signature and credentials of individual rendering service.

Therapy notes/grids

Therapy notes are categorized as initial evaluation or re-evaluation visit notes. Documentation is for all billed therapy services provided to the patient during the requested episode of care. Grids are ‘calendar type’ boxes for checking off days in the month when a specific therapy was provided.

Treatment and administration record

Documentation supporting specific billed service(s) administered to a patient by a healthcare professional. This can be used to support the following but not limited to: DME item being repaired or replaced, medication administration, wound treatment, respiratory therapy and any other therapies. Documentation includes but is not limited to: patient identifiers (name and date of birth), date of service, details of treatment provided, patient response and signature with credentials of individual rendering treatment.

Treatment plan notes

Physician documentation of a strategy of procedures and appointments designed to treat a specific diagnosis. The notes must include the advantages, disadvantages, costs, alternatives and sequence of treatments, along with the signature and credentials of the physician.

Back to top

Treatment plans (initial and updated), including all therapy and progress notes for dates of service billed

Documentation of a strategy of procedures and appointments designed to treat a specific diagnosis. Documentation must include: advantages, disadvantages, costs, alternatives and sequence of treatments, mental or behavioral health treatment plan with goals, interventions, and anticipated achievement dates signed by licensed provider within 72 hours of admission, therapy notes detailing the encounter, time spent and individual (with credentials) rendering service, patient participation and progress notes, including exam notes by a physician, nurse practitioner, physician's assistant and office personnel.

UB-04

The UB-04 is the claim form for institutional facilities and is used for: surgery, radiology, laboratory or other facility services.

Waste documentation

Documentation supporting the amount of a discarded drug or biologic that is only available in a single-does package. The patient may not need the full vial amount so the remaining medication in a vial cannot be used again. Documentation to include, but not limited to: patient identifiers (name and date of birth), date of service, number of units left in the vial that was not used or wasted and signature and credentials of individual rendering service.

Wound care consult and treatment notes

Documentation supporting the wound etiology or cause (pressure, venous, arterial, surgical, etc.), wound odor (strong, foul, pungent, etc.), wound location, described with proper anatomical terms, thickness characteristics for non-pressure wounds, partial-thickness wounds, tissue destruction through the epidermis that extends into but not through the dermis and full-thickness wounds, tissue destruction that extends through the dermis to involve subcutaneous tissue and possible bone or muscle, wound size measured in centimeters to include length, width and depth, wound bed characteristics, including tissue amounts and types (granulation, slough, eschar, epithelialization), and indication of infection, including fever, erythema, increased drainage, odor, warmth, edema, elevated white blood cell count, induration and pain. Documentation must include but is not limited to: patient identifiers (name and date of birth), date of service and narrative of wound care with nurse's signature.