CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 438	**Date: November 9, 2012**
	Change Request 8033

SUBJECT: Progress Notes and Forms

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to define Progress Notes, Progress Note Template, and Supplemental Form as well as guidelines regarding which documents Review Contractors must consider when making a determination utilizing the following: Progress Notes, Limited Space Progress Note Template, Open Ended Progress Note Template and Supplemental Forms.

EFFECTIVE DATE: December 10, 2012
IMPLEMENTATION DATE: December 10, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
N	3/3.3.2.1.1 Progress Notes and Forms

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out with their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 438	Date: November 9, 2012	Change Request: 8033

SUBJECT: Progress Notes and Forms

EFFECTIVE DATE: December 10, 2012
IMPLEMENTATION DATE: December 10, 2012

I. GENERAL INFORMATION

A. Background: In the past, review contractor were to consider any documentation to support pre- and post-payment determinations. Review contractors shall now consider all permanent medical record entries even those entries created using Limited Space Templates and extract any usable information relevant to the claim made by the physician, treating practitioner, or licensed/certified medical professional (LCMP) regarding the in-person visit.

B. Policy: The purpose of this change request (CR) is to define Progress Notes, Progress Note Template, and Supplemental Form as well as guidelines regarding which documents Review Contractors must consider when making a determination utilizing the following: Progress Notes, Limited Space Progress Note Template, Open Ended Progress Note Template and Supplemental Forms.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8033.1	The review contractor shall consider all permanent medical record entries made by physician, treating practitioner, or licensed/certified medical professional (LCMP) regarding the in-person visit.	X	X	X								CERT, Medicare RACs, ZPICS
8033.2	Review contractors shall review all medical record entries completed and signed by physicians or treating practitioners, even those medical record entries created using Limited Space Templates.	X	X	X								CERT, Medicare RACs, ZPICS
8033.2.1	Review contractors shall extract any usable information relevant to the claim.	X	X	X								CERT, Medicare RACs, ZPICS
8033.3	Review contractors shall remember that progress notes created with Limited Space Templates in the absence of other acceptable medical record entries do NOT constitute sufficient documentation of a face-to-face visit and medical examination.	X	X	X								CERT, Medicare RACs, ZPICS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Donna Jones, donna.jones3@cms.hhs.gov , Kathleen Wallace, kathleen.wallace@cms.hhs.gov , Debbie Skinner, 410-786-7480 or Debbie.Skinner@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out with their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

Table of Contents
(Rev.438, Issued: 11-09-12)

Transmittals for Chapter 3

3.3.2.1.1 Progress Notes and Templates
(Rev.438, Issued: 11-09-12, Effective: 12-10-12, Implementation: 12-10-12)

A. Definitions

For the purposes of Section 3.3.2.1.1, the following definitions apply:

1. ***"Progress Notes"*** *-- visit notes, encounter notes, Evaluation and Management documentation, office notes, face-to-face evaluation notes or any other type of record of the services provided by a physician or other licensed/certified medical professional (LCMP) in the medical record. Progress notes may be in any form or format, hardcopy or electronic.*

2. ***"Template"*** *-- a tool/instrument/interface that assists in documenting a progress note. Templates may be paper or electronic.*

Electronic records may involve any type of interface including but not limited to:

- *simple electronic documents,*
- *sophisticated graphical user interfaces (GUIs) with clinical decision and documentation support prompts, or*
- *electronic pen capture devices.*

3. ***"Licensed/Certified Medical Professional (LCMP)"*** *– Medical professional licensed or certified to practice in the state in which services are rendered. For the purposes of documenting DMEPOS items, the physician or LCMP must not have a financial relationship with the DMEPOS supplier.*

B. Guidelines Regarding Which Documents Review Contractors Will Consider

The review contractor shall consider all medical record entries made by physicians and LCMPs. See PIM 3.3.2.5 regarding consideration of Amendments, Corrections and Delayed Entries in Medical Documentation.

The amount of necessary clinical information needed to demonstrate that all coverage and coding requirements are met will vary depending on the item/service. See the Local Coverage Determination for further details.

CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse or approve any particular templates. A physician/LCMP may choose any template to assist in documenting medical information.

Some templates provide limited options and/or space for the collection of information such as by using "check boxes," predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

Physician/LCMPs should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.

If a physician/LCMP chooses to use a template during the patient visit, CMS encourages them to ***select one that allows for a full and complete collection of information*** *to demonstrate that the applicable coverage and coding criteria are met.*

CMS recommends that the physician/LCMP document in their usual medical record keeping format.

Certificates of Medical Necessity (CMN), DME Information Forms (DIF), supplier prepared statements and physician attestations by themselves do ***NOT*** *provide sufficient documentation of medical necessity, even if*

*signed by the signed by the ordering physician. These types of documents will **NOT** be considered by the contractor when making a coverage/coding determination. See PIM §5.7 for additional information on documentation.*

C. Financial Liability

The physician/LCMP should be aware that inadequate medical record documentation can lead to a financial liability for the Beneficiary and/or Supplier, should the reviewer determine that a claim is not supported.

In addition, the physician/LCMP should be aware that when ordering an item or service that will be furnished by another entity, Section 1842(p)(4) of the Social Security Act requires that adequate documentation supporting medical necessity be provided to the entity at the time that the item or service is ordered. Physicians/LCMPs who fail submit documentation upon a supplier's request may trigger increased MAC or RAC review of the physician/LCMP's evaluation and management services.