THE HEALTH PLAN
CLINICAL RECORD DOCUMENTATION GUIDELINES

April 21, 2022

The Health Plan (THP) requires a consistent, legible, responsible method of record keeping for all provider entities. These guidelines will provide entities with standards to ensure medical record documentation is pertinent, accurate, and complete for all services performed. Failure to follow the guidelines may result in a delay, claim processing errors, or even denial.

1) All medical records must be easily readable and clear. Illegible records potentially affect patient care and cannot be appropriately reviewed. Claims could be denied if the reviewer cannot reasonably read the supporting documents submitted. "Reasonably" is defined as easily recognizable by someone outside the practice who is unfamiliar with the handwriting.

2.) Signatures:
   a) All records used to document services rendered for payment must be appropriately signed and include the credentials of the individual signing.
   b) Signatures may be handwritten, initialed over a typed or printed name, or may be authenticated electronic signatures. If a signature is handwritten and illegible, it must be accompanied by a typed or printed copy of the signature including credentials.
   c) Electronic signatures must include a date and time stamp and the provider's name and credentials. Stamped signatures are not acceptable. Credentials may be listed in the letterhead of the record.
   d) Signatures of supervisory personnel must occur (indicating review and approval of the documentation) within one week of the visit. Supervisors are responsible for the quality of the supervisee's documentation and timeliness of entry.

3.) Time-based services: Services that are time based (billable by a specific unit of time) must include the duration, preferably stated in start and stop times, often required by Mountain Health Trust guidelines. Please note that West Virginia Medicaid Provider Manual Chapter 519 requires that the time the practitioner spent with the member for medical decision-making be documented when the claim is for evaluation and management codes. Click here for more information.

4.) Timeliness:
   a) The Centers for Medicare and Medicaid Services (CMS) require that documentation be signed "as soon as practicable after the service is provided to maintain an accurate medical record". The provider entity must have a policy regarding timeliness of signature for the provider of clinical services as

well as any required signing by supervisors. If the provider has no such policy, The Health Plan's standard shall apply, which is that documentation must be signed within 72 hours unless some reason for extending that deadline is offered in the record.

b) Entries should not be made in advance of a service rendered.
c) Exceptions can be made if explained or justified within the clinical record.

5.) Altered, amended or addended medical records:
   a) The medical record cannot be altered. Corrections may be made, so long as the original documentation remains and is clearly marked as corrected.
   b) Providers may not write over, white out, delete, or erase a prior entry. The correction should be marked through with a straight line, initialed and dated, and followed by the correct information with the current date and initial.
   c) Electronic records must clearly identify the original error and the correction, date and time of correction, individual correcting, and reason for correction. Hard copies must show this information.
   d) Addenda may be made only when the correct information was not available at the time of the original documentation. Exceptions may be made for entries that are accidentally entered into the incorrect patient file. Addenda should be the exception rather than a rule. At a minimum, addenda must include:
      i. Statement indicating that the entry is an addendum,
      ii. Date and time the record is being amended,
      iii. Details of the amended information, and
      iv. Signature of the provider writing the addendum

6.) Templated, Copy and Paste, or Cloned medical records:
   a) Each medical record must be specific to the individual served. While templates may be used, there must be evidence other than checkmarks that individual treatment was provided, even in group settings. An individual with knowledge and/or experience in a relevant field reviewing the medical record must be provided with sufficient information in the clinical record to allow understanding of the member's current condition and the services provided. If the member has a master treatment plan, the treatment provided should refer to the goals and objectives of the master plan and provide information as to the issues addressed in the visit and the member's unique status at the time of treatment.
   b) Documentation must be specific to the patient and his/her situation at the time of the encounter.
   c) Documentation that is copied and pasted (cloned) from one visit to the next or from one patient to another is never acceptable.
   d) Clinical documentation can only be carried forward if it is accompanied by dated and signed documentation updating member status individually, as described above.

7.) The clinician may add explanation in the medical record for anomalies in entries, and that explanation will be taken into account during THP review.

References/Helpful Links:

WV Bureau of Medical Services Chapter 519.8 Practitioner Services: https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Chapter%20519.8-Practitioner%20Services%20FINAL.pdf

CMS Documentation Matters Toolkit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Documentation
AMA Implementing CPT Evaluation and Management Revisions: https://www.ama-assn.org/practice-management/cpt/implementing-cpt-evaluation-and-management-em-revisions

MLN Matters Complying with Medicare Signature Requirements: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/signature_requirements_fact_sheet_icn905364.pdf