



Chapter 4

Medical Records



Medical records are the primary source of clinical information used to support patient care and ensure continuity of care. The Health Plan (THP) requires medical records to be complete, accurate, and consistent with federal and state regulations, the National Committee for Quality Assurance (NCQA) requirements, and THP policies and procedures for all lines of business, unless otherwise noted.

Medical Records and Confidentiality Statement

The medical records and confidentiality statement ensures that a separate comprehensive medical record is created and maintained for each member. Member medical records shall include all relevant biographical and medical information to promote quality care. Medical records must be maintained in a confidential manner.

All participating practitioners shall maintain a current member medical record in accordance with THP standards for member records and in compliance with all federal and state laws and regulations.

All practitioners shall preserve all records related to members for a period of not less than ten (10) years, longer if the records are under review or audit.

Medical records shall be made available, as required, to each practitioner treating the member. Medical records must be made available or provided upon request to an authorized representative of THP and to appropriate state and federal authorities, or their delegates, for medical record audit, quality improvement activities and initiatives, utilization review, investigation of member grievances or complaints, fiscal audit, program integrity review including pre- or post-payment review, and other regulatory auditing or monitoring initiatives.

Medical records and member information should only be accessed by the appropriate personnel as necessary to complete required job functions. All medical records and member identifying information are subject to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and should be treated as such.

Medical Records Request and Review

THP conducts pre- and post-payment medical record reviews. Practitioners may receive a medical records request for care delivered to THP members. Practitioners are required to provide records securely, in a timely manner, and at no cost to THP unless otherwise specified in the practitioner agreement. The record request may come directly from THP or an organization conducting a review on THP's behalf. Medical records should be submitted with a copy of the original request to ensure proper processing.

If a response timeframe is not stated in the medical record request, records must be provided within 30 calendar days from the date of the request. Practitioners should notify the requester regarding extension requests. Failure to provide the requested records within the required timeframe may result in claim denial or other adverse actions, including termination from THP's network.

Practitioners who submit medical records that do not meet medical record requirements and standards are notified of the audit findings and provided educational resources. As applicable, the practitioner will be required to submit a corrective action plan and may be subject to additional pre- or post-payment reviews.



Standards for Medical Records

1. Identification, Care, and History

Each medical record entry must be specific to a single, clearly identified, and named member and the services rendered by the practitioner(s). Medical records should contain the following, as applicable:

- All information needed to conduct utilization review or support services billed;
- Member identification information, including name and/or identification number on each page or electronic file;
- Personal/biographical data, including age, sex, address, employer, home and work phone numbers, and marital status;
- Date of entry and/or service date;
- Practitioner identification (including credentials) for all practitioner(s) involved in the specific episode of care;
- A list of allergies, when appropriate for the service type;
- Past medical history;
- Completed immunization record or notation for members aged 12 and under to indicate immunizations are up-to-date and when subsequent immunizations are required, as appropriate for service type;
- Diagnostic information;
- Medication information;
- Identification of current problems, including significant illness, medical conditions, and health maintenance concerns;
- Smoking/ethanol/substance use notations (as appropriate) concerning cigarette and alcohol use and substance use (if present) for members 14 years of age and over and when seen three (3) or more times;
- Consultations, referrals, and specialist reports, including notes from consultations, lab reports, and x-ray reports with the ordering practitioner's initials or other documentation signifying review, such as an explicit notation in the record and follow-up plans for significantly abnormal lab and imaging study results;
- Documentation of emergency care provided;
- Hospital discharge summaries for hospital admissions including prior admissions and admissions that occur while the member is enrolled in the plan;
- Advance directives, including documentation of whether the member has executed an advance directive;
- Visit data for each individual encounter, including adequate evidence of the following:
 - History and physical examination, including appropriate subjective and objective information for the presenting complaint
 - Plan of treatment
 - Diagnostic testing
 - Therapies and other prescribed regimens
 - Follow-up activities, including encounter forms with notations concerning follow-up care or visits, with return times noted in weeks, months, or as needed, and documentation demonstrating unresolved problems were addressed at subsequent visits
 - All other aspects of care, including ancillary services



2. Legibility

Medical records must be legible and understandable to someone other than the writer. Any record judged as illegible will be evaluated by a second reviewer. If both reviewers are unable to read the record, it will be deemed “illegible” and may result in claim denial or other appropriate action, depending on the reason(s) for review.

3. Stand Alone

Medical records submitted to support a claim must “stand-alone”, meaning only information necessary to support the services and diagnoses billed are included. References to other records are acceptable, but only if the referenced records are also provided for review and support the medical necessity of the service(s) billed. For example, if the treating practitioner refers to the goals and objectives of the member’s treatment plan to provide context to the issues addressed in the visit, the treatment plan should be included in the documentation provided for review.

4. Signatures

Medical records must be appropriately signed by the individual practitioner who rendered the services, including the individual’s professional credentials and date and time of signature. Signatures may be handwritten, initials over a typed or printed name, or authenticated electronically. If a signature is handwritten and illegible, it must be accompanied by a typed or printed copy of the practitioner’s signature including their professional credentials.

Electronic signatures must include a date and time and the practitioner’s name and credentials. Signature stamps are not acceptable, except when needed to accommodate a physical disability.

Practitioners may include a signature log in their medical record submissions that includes the typed or printed full name of the practitioner(s) who rendered the services and their professional credentials. The practitioner’s title or role may be used in lieu of credentials, as applicable.

a. Supervisory Signatures

The signature of supervisory personnel indicates their review and approval of the documentation. Supervisory personnel signatures must be included when appropriate or required to substantiate rendered services.

b. Signature Timeliness

The Centers for Medicare and Medicaid Services (CMS) require that medical records be signed “as soon as practicable after the service is provided to maintain an accurate medical record.”

THP follows CMS’ guidelines for signature requirements unless preempted by another authority such as the West Virginia Bureau for Medical Services (WV BMS) Provider Manual. THP defines “as soon as practicable” to mean:



A time reasonable, upon completion of the service, for the practitioner to sign the documentation as complete and accurate, not to exceed five (5) business days or seven (7) calendar days, unless the reason for delay is specifically noted in the individual medical record. The signature of a supervisor, when required, must be made within five (5) business days of the signature of the individual being supervised.

Documentation may not be signed in advance of the service being rendered and must be completed prior to submitting a claim. Exceptions may be considered if justified within the medical record or through a properly documented addendum or attestation.

c. Orders for Services

Medical records for the following services must contain an order signed by an appropriately qualified individual:

- Testing, e.g., routine, diagnostic, genetic;
- Admission to a facility, program, or course of treatment that requires a qualified medical practitioner order; and
- Durable Medical Equipment, Prosthetics, Orthotics, Supplies

5. Time-Based Services

Services that are time-based (billable by unit for a specific amount of time spent rendering the service) must include the duration of the service in start and stop times, as applicable or required by the service billed.

Evaluation and Management Services

Medical records for evaluation and management (E&M) services must be individualized and include the member's health history, care, findings, and observations including the following as applicable:

- Billed procedure code components
- Time the practitioner spent with the member and/or the number and complexity of problems addressed during the encounter
- Reason for the encounter and the relevant history, findings of the physical examination, and prior test results
- Assessment and diagnosis
- Comorbidities and/or risk of mortality
- Treatment Plan

The WV BMS Provider Manual Chapter 519 “Practitioner Services” for Mountain Health Trust (WV Medicaid and CHIP) requires documentation of time the practitioner spent with the member for medical decision making (MDM), even if the level supported is based on MDM rather than time.



Use of Imagery

The inclusion of images, (e.g., photographs, x-rays, scans), in medical records are encouraged when available and must be clearly labeled to include:

- Member name;
- Date the image was obtained;
- Anatomical location of image or indication of view; and
- Relevant scale, if applicable

Telehealth Services

Telehealth medical records must meet the same requirements and standards as those for an in-person visit.

The member's consent to receive treatment through telehealth must be obtained verbally or in writing. If the consent is obtained verbally, it must be documented in the record. The consent may be included in the member's initial general consent for treatment or documented in the medical record for each telehealth visit.

The audio, video, or computer telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunication equipment must be of a quality sufficient to complete all necessary components of the services rendered. For example, if a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality to support medical decision making.

Medical records must include the mode of communication used for the telehealth service. Electronic mail messages, e.g., email, SMS text messaging, facsimile, may be documented in the medical record but may not be billed for reimbursement.

The location of both the practitioner and member must be documented in the medical record to support place of service billed. If the practitioner has more than one office location, the address of the telehealth encounter should be included.

The practitioner at the distant site is responsible for maintaining the standards of care within their scope of practice.

Drug Screenings

Medical records must clearly state the medical necessity of drug test(s) ordered and include drug name, diagnoses, and reason for the encounter. Test results, specific findings, and the practitioner's actions in response to the results should be included. A nonspecific or unspecified diagnosis does not satisfy the requirement for drug testing.

Point of care testing refers to testing completed in the practitioner's office and must have an order, prior authorization (if required), or plan indicating testing was ordered and performed. This documentation must be included within the signed encounter note and include all findings, whether included in the same note, an addendum, or an additional progress note.

Routine reflex testing is not a covered service for Mountain Health Trust (WV Medicaid and CHIP) members. Reflex testing occurs when an initial result meets pre-determined criteria, and an additional test is performed automatically based on the pre-determined criteria without a separate order from the treating practitioner.



Altered, Amended, or Addended Records

Once medical records are created, they cannot be altered. Corrections or amendments may be made if the original documentation remains and is clearly marked as corrected or amended. Practitioners may not write over, white-out, delete, or erase a prior entry. The correction or amendment should be marked through with a straight line, initialed, dated, and followed by the updated information.

Electronic medical records must clearly identify the original documentation and the correction or amendment with the date, time of correction/amendment, identity of the individual making the correction/amendment, and reason(s) for the correction/amendment. Printed electronic medical records must also include this information.

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 inadvertently entered into an incorrect member file. At a minimum, an addendum must include:

- A statement indicating that the entry is an addendum;
- The date and time the record was addended;
- The details of the addended information; and
- The signature of the practitioner writing the addendum.

Practitioners may not create a new separate entry to replace an existing entry in lieu of adding an addendum.

Templated, Copy-and-Paste, or Replicated Records

Each medical record must be specific to the individual service and member. Medical record templates must include evidence 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 medical record to support an understanding of the member's current condition and services provided.

Documentation that is copied-and-pasted (replicated) from one visit to the next or from one member to another member is prohibited. Replicated records do not support services billed.

Medical record documentation can be carried forward only if accompanied by dated and signed documentation updating the member's status individually, as described above.

The practitioner may add an explanation in the medical record for any medical record anomalies.

Electronic Health Records (EHR)

Practitioners utilizing EHRs should maintain policies and procedures to:

- Prevent loss or destruction of the EHR.
- Promote secure electronic exchange of member information when authorized.
- Avoid creation of replicated documentation.
- Ensure each entry in the EHR includes proper validation, including the practitioner's name, credentials, date, time, and source of data.



- Verify the validity of auto-populated information. Auto-populated information is data that does not require positive action or is the result of abbreviated words or keystrokes.
- Prevent fraud, waste, and abuse for practitioners utilizing e-prescribing.
- Where allowable by law, ensure documentation created by artificial intelligence (AI) is clearly denoted as such and is reviewed for accuracy and verified by a human signatory. If AI is used, it must be HIPAA-compliant.
- If templates are used, the material entered must be individualized and relevant to the presenting problem(s) and service(s) provided during that encounter.
- Accommodate the identification and signatures of multiple individuals so that the author of each entry in the record is clearly identified.



Common Coding Scenarios

1. History vs. Active – Congestive Heart Failure (CHF)
 - **What was documented:** "Patient has a history of CHF. Compensated on home regimen. Continue furosemide 40mg daily, metoprolol succinate 50mg daily, and spironolactone 25mg daily."
 - **What was coded:** Z86.79 — Personal history of other diseases
 - **The problem:** "History of" implies the condition is resolved and no longer exists. However, this patient is on three (3) daily medications specifically for heart failure management. CHF is actively managed, not a resolved condition. If a patient requires ongoing medication, monitoring, or treatment for a chronic condition, it is active, not a history of.
 - **What should be coded:**
 - **I50.9** — Heart failure, unspecified (*at minimum*)
 - **I50.22** — Chronic systolic heart failure (*if EF documented as reduced*)
 - **I50.32** — Chronic diastolic heart failure (*if EF preserved and documented as diastolic*)
 - **I50.42** — Chronic combined systolic and diastolic heart failure (*if both documented*)

2. Missed Specificity – Heart Failure Type
 - **What was documented:** "Chronic systolic heart failure, ejection fraction 35-40%, NYHA Class II symptoms. Stable on current regimen."
 - **What was coded:** I50.9 — Heart failure, unspecified
 - **The problem:** The practitioner explicitly documented "systolic heart failure" and gave an ejection fraction. ICD10-CM has distinct codes for systolic, diastolic, and combined heart failure. Coding to I50.9 ignores clinical specificity that affects patient severity profiles.
 - **What should be coded:** I50.22 — Chronic systolic heart failure (*specific to documented type*) or, if documented:

Description	Code
"Acute on chronic systolic HF"	I50.23
"Diastolic HF, EF > 50%"	I50.32
"Acute on chronic diastolic HF"	I50.33
"Combined systolic and diastolic HF"	I50.42
"Acute on chronic combined HF"	I50.43