Medical Record Documentation

Documentation is the recording of pertinent facts and observations about a patients health history, including past and present illnesses, diagnostic tests, treatments and outcomes. Consistent and complete documentation in the medical record is an essential component of quality patient care. Maintenance of appropriate medical record documentation is also a required component of all provider agreements.

All services billed to Blue Cross and Blue Shield of Alabama must be supported by accurate documentation to determine the appropriate benefit application, including: verification that the services were rendered; justification of the medical necessity and quality of the care provided; and validation of accurate claims submissions. The documented services should be reflected accurately on claims by using the Current Procedural Terminology (CPT) codes; Healthcare Procedure Coding System (HCPCS) codes; and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes or descriptions as required.

Services submitted for payment but undocumented in the medical record are unable to be validated and, therefore, ineligible for reimbursement. Additional guidelines for documentation and coverage may be found in our specialty provider manuals (e.g., Chiropractor, Anesthesia, etc.), the Provider Manual (Preferred Occupational Therapist, Preferred DME and Preferred Physical Therapist) and in our medical policies. These resources are available online. Below is a general list of medical record content and documentation guidelines used for review purposes:

- The record is legible to someone other than the author (a third party reviewer).
- Electronic medical records, such as template records, are updated and individualized with each patient encounter.
- The author signs the record/treatment note, the signature is legible and includes the authors professional credentials (MD, RPT, etc.). Provider codes and stamps are not acceptable. Unsigned notes and documentation will not be accepted as verification of services provided.
- The medical record should be written in English.
- Each page of the record contains the members name or identification number.
- Significant illnesses as well as medical and psychological conditions are indicated on the problem list.
- Past medical history is easily identified and includes serious accidents, operations and illnesses.
- The current history and physical examination documents appropriate subjective and objective information pertinent to the members current presenting complaints.
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions) is documented.
- Information on advance directives is documented as applicable.
- Identification of all providers participating in the patients care and information on services furnished by these providers is present.
- Prescribed medications, including dosages and dates of initial or refill prescriptions, is documented.
- All diagnostic testing or procedure reports and their interpretations are present (example laboratory reports, radiology reports, pathology reports).
- All services that were provided including any procedures performed, medications administered and supplies dispensed are documented with specificity.
- Consultation referrals and reports are maintained in the record.
- Administrative documents pertinent to the members care are maintained in the record. This includes, but is not limited to completed precertification forms, certificates of medical necessity and referrals to other providers of care.

- The baseline level of the patients function with objective measurements and appropriate care plans are documented when a patients treatment is of a repetitive nature or multiple visits are expected.
- Re-evaluation documentation is present for chronic conditions or conditions that require follow-up.

For additional information regarding medical record documentation, please refer to the following resources:

- Blue Cross and Blue Shield of Alabama Provider Manuals
- Evaluation & Management Services Guide - Medicare Learning Network
- Medical Records Management - Board of Medical Examiners Administrative Rule 540-X-.10; Medical Licensure Commission Administrative Rules, 545-X-4-.08.
- Minimum Standards for Medical Records - Medical Licensure Commission Administrative Rules, 545-X-4-.06.
- Failure to competently manage medical records - Medical Licensure Commission Administrative Rules, 545-X-4-.09.