General Notification

Notification Date: 07/02/2024

To: All Providers
From: MDwise Provider Relations
Subject: Medical Records: Provider Responsibilities
Effective Date: July 2, 2024

Summary

MDwise would like to thank our providers for consistently documenting patient medical records and coordinating care on behalf of our members. Your dedication to serving your patients is commendable.

MDwise providers and practitioners are responsible for maintaining medical records to facilitate communication, coordination, and continuity of care and promote efficient and effective treatment. Upon request, providers and practitioners must provide copies of patient medical records to CMS, the State, the health plan and their designees at no cost. Sharing medical records for payment, continuity of care, quality of care and monitoring/oversight is a requirement.

Action

Medical Record Standards are outlined in 42 CFR 431.305, provider contracts, IHCP guidelines and NCQA standards. These standards apply to:

- All services provided directly by a practitioner who provides primary care services.
- All ancillary services and diagnostic tests ordered by a practitioner.
- All diagnostic and therapeutic services for which a member was referred by a practitioner, including but not limited to:
    - Home Health Nursing
    - Specialty Physician
    - Hospital Discharge
    - Physical Therapy

Providers and practitioners must maintain policies and procedures that address:

- Confidentiality of patient information
- Secure storage that allows access by authorized personnel only
- Medical record content
- Medical record organization (must be consistent)
- Ease of retrieving medical records

- Information documents must meet minimum documentation standards

Minimum health records documentation standards include:

- Allergies and adverse reactions
- Problem list
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screen
- The identity of the patient receiving the services
- The identity of the provider rendering the service
- The identity, including date signature or initials, and position of the provider
- Employee rendering the service, if applicable
- The date on which the service was rendered
- The diagnosis of the medical condition of the individual to whom service was rendered
- A detailed statement describing services rendered, including duration of services rendered
- The location at which services were rendered
- Written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document the acute medical needs
- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment and ongoing evaluations as to assess progress and refine goals
- Ancillary services and diagnostic tests ordered by a practitioner including but not limited to: X-rays, mammograms, electrocardiograms, ultrasounds and other electronic imaging records

Additional information may be required by the nature of the services provided including but not limited to:

- Prescriptions for medications
- Inpatient discharge summaries
- History and physicals including immunizations
- Record of substances used and/or abused, including alcohol, tobacco and legal and illegal drugs
- Ancillary, outpatient and emergency care provided

Thank you for your continued efforts for documentation of exceptional patient care.

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