Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Medical Record Documentation Standards for Practitioners

Well-documented medical records facilitate communication, coordination and continuity of care, and promote the efficiency and effectiveness of treatment. Aetna Better Health of West Virginia requires that practitioners have organized medical record keeping systems and standards for availability of medical records. All practitioner offices are expected to have Medical records stored in a secure manner that allows for easy retrieval and access by authorized personnel only. Office staff should receive periodic training in member information confidentiality.

On an annual basis, the quality department performs an audit on a random sampling of member medical records to assess compliance with the following medical record documentation standards. Practitioner offices that are included in the audit will receive written notification of their results. Overall results of the audit will be included on the Aetna Better Health Provider Website.

Medical Record Documentation Standards		
1	***Name or ID present on each page of the record***	The patient's name or ID number should be recorded on each page of the medical record or electronic file (i.e. all notes, lab reports and consult reports).
2	**Personal Data**	The record contains appropriate personal data such as age, sex, address, employer, home and work telephone numbers, and marital status, as applicable. All patients must have their own chart.
3	**Entries in the record contain author signature or initials**	The provider of service for face-to-face encounters must be appropriately identified on medical records via their signature and physician specialty credentials (e.g., MD, DO, DPM etc). Examples of acceptable physician signatures are: handwritten signature or initials; electronic signature with authentication by the respective provider; or facsimiles of original written or electronic signatures. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations to the record are signed.
4	**All entries are dated**	
5	**Legibility**	The medical record should be complete and legible to someone other than the writer.
6	**Allergies**	Medication allergies and adverse reactions are prominently noted in chart. Absence of allergies (noted as NKA – no known allergies) is noted in an easily recognized location.
7	**Past Medical History Completed and is easily identified** (for patients seen three or more times)	Past history including serious accidents, operations, and illnesses. Family history including a review of medical event, diseases, and hereditary conditions that may place the patient at risk may be included. For children past medical history relates to prenatal care, birth.
8	**Age Appropriate Immunization record** (for patients 13 and under)	An immunization record (for children up to age 13) is up to date.

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9	**Prescribed Meds, including dosages and dates of initial or refill Rx**	Evidence of prescribed medications, including dosages and dates of initial or refill prescriptions are present in the record. This list should be updated each visit.
10	**Identification of Current Problems**	Significant illness, medical condition, psychological conditions, and health maintenance concerns are identified in the medical record. Format can be a classical separate listing of problems or an updated summary of problems in the progress note section (usually during a periodic health exam). During a well-child visit, for children between ages of 3 and 17, counseling for nutrition and physical activity is documented at least annually.
11	**Alcohol/ Substance Use/ Smoking*** (For patients 12 years or older, seen three or more times)	For patients 12 years and older, there is documentation concerning alcohol, tobacco products, and/or substance use.
12	**Consultations, referral and specialist reports**	Consultations, referrals, labs, and x-ray reports have the ordering physician's initials or other documentation signifying review or are documented in progress notes; significantly abnormal lab and imaging study results have as explicit notation in the record and follow-up plans.
13	**Communication/Discharge summaries regarding emergency care and hospitalizations.**	There is evidence of communication/ discharge summaries from the hospitals and/or Emergency Care if applicable.
14	**Family Planning/Reproductive Health** (For patients 15-44, seen three or more times)	For patients 15-44 years old, there is documentation of family planning discussion, including assessments of sexual activity, contraception, STD screening, and/or counseling.
15	**Advanced Directives present** (for patients 18 years of age or older)	There is evidence of advance directives noted and whether or not the advance directive has been executed in the chart for patients 18 years of age or older.
16	**History and Physical examination**	Appropriate subjective and objective information is obtained for the presenting complaints at each visit.
17	**Treatment Plan**	Treatment Plan (prescriptions, studies, instructions, diagnostic, therapeutic procedures) is documented and appropriate for the patient's diagnosis and risk factors.
18	**Diagnostics tests and therapies**	If a diagnostic service (test or procedure) or therapy is ordered, planned, scheduled, or performed at the time of the encounter, the type of service, e.g., lab or x-ray should be documented.
19	**Follow-up Plan/ Return Visit for each Encounter**	Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.

*Age recommendation is based on HEDIS Technical Specifications