Tips for Properly Preparing Medical Records

The complete medical record regarding the entire episode of care must be captured, including but not limited to:

- All medical record documentation necessary to support the services that were billed, regardless of the place of service, such as inpatient, outpatient hospital, office or nursing facility.
- As emergency room, outpatient hospital, or observation periods, transfer records, etc., may precede or follow the inpatient portion, they must be included, even if they fall outside of the dates of the claim as billed.
- A complete medical record includes, but is not limited to:
    - Emergency room record
    - A History and Physical
    - A Discharge Summary
    - Physician progress notes
    - Physician orders
    - Operative reports and procedure notes
    - Anesthesia records
    - Pathology reports
    - Consultation reports
    - Complete Nurses' notes, including vital signs
    - Medication Administration Records
    - Laboratory reports
    - Radiology reports

- Special diagnostic reports
- Consent forms for admission, treatment, and procedures.
- Signature sheets for everyone who provided services during the time period
- Hospital face sheets and coding documentation
- Any transfer records and relevant outside facility records

- All other documents that were made a part of the client's records for the specified dates.
- To allow for more efficient and accurate reviews, it is very helpful if page numbers are included, so that appeal letters can reference the location of key elements, such as admission or observation orders, the discharged summary, and any other records noted above.

If this is an appeal of a non-RAC claim denied as a re-admission:

- The complete medical records for the prior encounter and any intervening hospital outpatient or ED visits must also be submitted and certified by a separate affidavit.

When preparing paper medical records for submission:

- The documents should be printed one-sided.
- All pages should be verified as legible and complete.
- Pages should be numbered sequentially during the printing process or by hand-written numbering.
  - This helps ensure that the page count needed for the affidavit is correct and assists in locating key documentation.
  - **Note:** Page numbering is the only allowed alteration to medical records.

When submitting records on CD:

- Only one medical record is allowed per CD.
- The CD must be attached to an affidavit certifying the CD as containing an exact copy of the original medical record.

- If the affidavit was signed prior to the creation of the CD, it is not valid.
- The affidavit should not be included on the CD. If a copy of the signed affidavit is on the CD, the presumption will be that the affidavit was signed prior to the creation of the CD and therefore is not valid.

- If the CD is password protected the password must be received prior to the submission deadline. This must be the verbatim, working password, rather than a lookup code requiring application of personal identifiers, such as date of birth.
- The files on the CD should be verified to open without requiring installation of encryption software.

Because the record is certified as an exact copy of the original medical record, no alterations may be made to the medical record.

- For example, no highlighting, mark-ups or other writing, or rearrangement of pages is permitted.
- An exception can be made only for numbering the pages prior to certifying by affidavit.
- It is recommended that the provider or their appeals agent make and keep a copy of the medical record submitted to HHSC Medical and UR Appeals.

When the affidavit is signed and notarized:

- The medical record (either on CD or paper) must be physically present and attached to the affidavit at the time of attestation.
- Other documentation should never be placed between the medical record and the affidavit. This includes the appeal letter, the OIG decisions letters, and any supporting documentation.

Once the medical record is certified by an attached affidavit:

- The medical affidavit and medical record should be considered a single, non-severable unit.
- Any alterations to the medical record or affidavit will invalidate the affidavit.

- The documentation should be bound by clips or rubber bands to prevent others from separating the medical record from the affidavit, re-ordering pages, or inserting other documentation between the affidavit and the medical records.