Providers and facilities must follow the requirements outlined in this section.

Medical recordkeeping requirements

We follow CMS standards for medical record documentation and signature authentication. For reference, please visit the following Medicare Learning Network (MLN) fact sheets:

- *Medical Record Maintenance & Access Requirements* (MLN4840534): cms.gov/files/document/mln4840534-medical-record-maintenance-and-access-requirements.pdf
- *Complying with Medical Record Documentation Requirements* (MLN909160): cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/certmedrecdoc-factsheet-icn909160.pdf
- *Complying with Medicare Signature Requirements* (MLN905364): cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

Providers and facilities must have the following:

- Policies regarding medical record confidentiality and release of information
- Procedures for assessing and improving content, legibility, organization and completeness of medical records

Providers must maintain a medical record-keeping system that:

- Permits encounter claim review
- Conforms to professional medical standards
- Permits an internal and external medical audit
- Facilitates an adequate system for follow-up treatment

All medical records must be maintained for at least 10 years after the date of medical services.

Medical records must contain all the necessary documentation to support the services rendered and billed, as well as the medical necessity of those services. Valid CPT® codes, ICD codes and Diagnostic and Statistical Manual of Mental Disorders (DSM) codes must be supported by the patient's medical record. If the appropriate documentation is not included, we may be unable to confirm that payment was made appropriately, which can result in requests for refunds from providers. **Note**: Starting with retrospective medical record reviews that begin on or after September 1, 2024, claims may subject to recoupment if we determine that CMS authentication or documentation requirements are not met.

Providers must include, at a minimum, the following in medical records:

- Specific and clear treatment plans
- Information on advance directives
- Complete, accurate and legible documentation
- Complete history, examination and medical decisions
- Identification of all providers participating in the patient's care
- Diagnostic testing, laboratory tests and radiology reports and results
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Complete descriptions of the patient's concerns and reason for seeking medical care
- A problem list, including significant illnesses and medical and psychological conditions
- Evaluation and assessment of the provider's findings and a complete list of all diagnoses
- Information on allergies and adverse reactions or a notation that the patient has no allergies or history of adverse reactions

Requirements for each page or entry in the medical record:

- Each entry must include progress notes, any improvement in the patient's condition, changes in the treatment plan and updates to the diagnosis
- Each page must include the patient's name, date of birth and date of service to verify who the patient is and what date services were provided.
- Each entry must have the rendering provider's signature at the completion of the chart note, medical records, operative report or any other medical document in a patient's file. If an entry spans multiple pages, the signature is required at the end of the entry, but patient identifiers need to be included on each page.