

Medical and Behavioral Health Records

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Documentation Standards and Record Keeping Practices

Fallon Health (FH) requires medical and behavioral health records to be maintained in a manner that is current, detailed, and organized and permits effective and confidential patient care and quality reviews.

Physicians/Providers contracted with Fallon Health are responsible for maintaining medical and behavioral health records for FH members in an organized medical and behavioral health record keeping system. Contracted practitioners must release in a timely manner copies of medical and behavioral health records requested by members, or other clinicians to ensure continuity and coordination of care, including but not limited to behavioral health treatment of enrollees who express suicidal or homicidal ideation or intent, consistent with Massachusetts state law.

Physicians/Providers contracted with FH must comply with FH's confidentiality policies related to release of medical information. Practitioners are responsible for providing access of medical and behavioral health records for review by the health plan for coding and chart documentation review and for quality monitoring activities. 45 CFR 164.502: Uses and disclosures of protected health information to carry out treatment, payment, or health care operations.

Risk-adjustment, Coding, and Medical Record Documentation Standards

Risk-adjustment: An Overview

For Physicians/Providers the most relevant aspect of the risk adjustment process is to document and code face to face visits accurately to describe each patient diagnostically as completely as possible. The CMS risk adjustment process includes using models to calculate risk scores, which predict individual beneficiaries' health care expenditures, relative to the average beneficiary. Risk scores are used to adjust payments and bids based on health status (diagnostic data) and demographic characteristics (such as age and gender) of an enrollee. Both the Medicare Advantage and Prescription Drug programs include risk adjustment as a component of the bidding and payment processes. CMS has developed separate risk-adjustment models for the Part A and Part B benefits offered by plans under Part C and for Part D benefits offered by prescription drug plans. Within each benefit, CMS also developed segments of the models for subpopulations with distinct cost patterns (Medicare Managed Care Manual, Chapter 7 Risk Adjustment 70. p. 9)

Internal Documentation and Coding Oversight

- FH requires providers to submit complete and accurate risk adjustment data.
- In all cases the documentation must support the code selected and submitted: professional 837P, facility 837I; professional CMS 1500 and facility UB04). These claims should substantiate that the proper coding guidelines were followed (42 CFR 310 (d) (4).
- Internal oversight of submitted diagnosis codes is conducted to ensure accuracy and integrity of risk adjustment data. If adjustments are made to diagnosis codes included in paid claims a Remittance Advice Summary ("RAS") is sent to the provider when a claim is adjusted.

External Documentation and Coding Risk Adjustment Validation Audits

- CMS annually conducts risk adjustment data validation audits (RADV) to ensure risk adjusted payment integrity and accuracy (42 CFR 422.311).
- MA organizations and their providers and practitioners need to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. The provider documentation in the medical record(s) must support each of the submitted diagnoses from face to face visits with the enrollee for specific date(s) of service (42 CFR 310 (d) (4).
- CMS Data validation ensures that both the medical record documentation and code(s) submitted are appropriate (42 CFR 310 (d) (4).
- MA organizations that undergo RADV audits will be issued an audit report post medical record review that describes the results of the RADV audit. Payment adjustments-if indicated-are included in the audit report (42 CFR 422.311).

Risk-adjustment: Guidelines for Medical Record Provider Documentation

1. Encounters must be from a face to face visit.
2. Patient's name and date of service must appear on all pages of the Progress note.
3. A unique identifier, either patient DOB, plan ID, or medical record #, should be on the first page of the Progress note.
 - If the Progress note is more than one page or two-sided, the pages must be numbered (i.e., p. 1 of 2). If pages are not numbered, then the provider must sign each page of the Progress note.
4. Each condition(s) being addressed should be documented in the medical record.
5. Each diagnosis should be documented to assign an ICD-9-CM code to the highest level of specificity.
6. Documentation must show that each condition was monitored, evaluated, assessed or treated (M-E-A-T) as appropriate on the date of the face to face visit as appropriate.
7. Documentation must include the reason for the visit as well as chronic conditions and acute conditions that co-exist at the time of the encounter/visit which require or affect patient care treatment or management.
8. Coding guidelines define the term "history of" as the patient no longer has the condition. Thus, Physicians/Providers should not document the term "history of" to describe an active condition/ disease.
9. Medical record must be legible, particularly the description of each condition.
10. Documentation should include only acceptable standard abbreviations.
11. Physician's/ Providers signature, credentials and date must appear on the Progress note in the medical record for each date of service.
12. Regulatory agencies recognize each Progress note as an "exclusive" or "stand alone" document.
13. Documentation should include the use of a "S-O-A-P" (subjective data, objective data, assessment, plan) type note to assist the physicians, providers, auditors and coders with clarity and consistency in identifying key documentation elements.

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- **Subjective:** (History; Chief Complaint) How the patients describe their problem or illness.
- **Objective:** (Physical Exam) Data obtained from examinations, labs results, vital signs.
- **Assessment:** (Medical Decision Making) assessment/evaluation of the patient’s current condition and status of all chronic conditions. How the objective data relate to the patient’s acute problem.
- **Plan:** (Medical Decision Making) of next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow up.

Sample Language:

Assessment / Evaluative Statement	Plan
Stable	Monitor
Improved	D/C med
Tolerating Med	Continue on current med
Deteriorating	Refer

Example:

Hypertensive CKD 3, stable well-controlled. Continue Atenolol.
Use this type of sample language as appropriate for EACH diagnosis.
Avoid blanket statements such as “all conditions stable, continue on meds”.

14. Patient diagnostic profiles are cleared for risk-adjustment every year on December 31st. Therefore, providers should document all diagnoses that are monitored, evaluated, assessed and treated each year.
15. Certain “health status” codes are very important to risk-adjustment. Examples include but are not limited to; patient undergoing dialysis, lower limb amputation status, patient undergoing dialysis, and Ostomies (specify type).

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16. A medical record that lacks a date or physician signature and credentials is invalid to use for risk adjustment.
17. When electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. Some samples of electronic medical record accepted signatures are "Electronically signed", "Authenticated by", "Signed by", "Validated by", or "Approved by"

Medicare Audit and Record Retention Requirements

Providers, and their downstream contracted entities, who contract with FCHP to provide services to Fallon Senior Plan members must comply with Medicare laws, regulations, and CMS instructions. CMS requires that records be maintained for a minimum of 10 years, and contracted providers agree to audits and inspection by the Department of Health and Human Services (HHS), the Comptroller General, or their designees, should the request arise, as well as cooperating, assisting, and providing information as requested.

What types of records does this apply to?

In accordance with federal regulations, the audit and inspection requirements described above apply to any books, contracts, medical records, patient care documentation, and other records of health care providers contracted with Medicare Advantage Health Plans, that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract between CMS and FCHP, or as the Secretary may deem necessary to enforce the contract between CMS and FCHP. Specifically, HHS, the Comptroller General, or their designee may evaluate, through inspection or other means the quality, appropriateness, and timeliness of services furnished to Medicare enrollees. Therefore, it is crucial that providers retain the types of records listed above for a minimum of 10 years.