

# Medical and behavioral health records

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*Note: Providers who are contracted with one of our vendor partners are also encouraged to review the provider manual published by our partners regarding requirements for the applicable specialty*

- American Specialty Health: <https://www.ashcompanies.com/Resource>
- Beacon Health Strategies: <https://www.beaconhealthoptions.com/providers/beacon/>
- Care Centrix: <https://help.carecentrix.com/ProviderResources/ProviderManual.pdf>
- Dental Benefit Providers: <https://www.dbp.com/content/provider/dental/dental-provider-resources.html>
- EyeMed: <https://eyemed.com/en-us/provider>

## **Documentation standards and record keeping practices**

Consistent with The Centers for Medicare and Medicaid Services (CMS) standards, as well as other applicable federal and state laws, Fallon Health (FH) requires that medical and behavioral health records must contain information to justify treatment, admission or continued hospitalization, support the diagnosis, and describe the patient's progress and responses to medications and services. Medical and behavioral health records must be confidentially maintained in a manner that is current, detailed, and organized and permits effective patient care and quality reviews. Providers are responsible for maintaining medical and behavioral health records for Fallon members in an organized medical and behavioral health record keeping system. Providers are also responsible for knowing the record requirements for their provider type.

All records must document, at a minimum, and in accordance with regulations and standards by the provider's license and specialty and/or facility type, relevant medical history, up to date examination of the patient, admitting diagnosis, consultative evaluations, complications, informed consent, discharge summary, final diagnosis with completion of medical records within 30 days following consultation or discharge. Records must be specific to the patient being treated; cloned records are not allowed. All corrections of medical records must be made within 30 days following consultation or discharge.

When an error is made in a medical record entry, proper error correction procedures must be followed for both paper and electronic records. For example, for paper records, a thin pen line should be drawn through the incorrect entry to make sure that the inaccurate information is still legible. The provider must state the reason for the error, document the correct information, and sign and date the correction. The original entry must not be obliterated or otherwise altered by blacking out with marker, using white out, and writing over an entry, or by other means. For electronic records, use an addendum to identify corrections due to errors. Providers may only document records using acceptable standard abbreviations from Jablonski's or Dorland's Dictionary of Medical Acronyms & Abbreviations. Documentation inserted or altered beyond 30 days of discharge or more than 30 days after the provider receives a request for records will not be considered.

All providers must release in a timely manner copies of medical and behavioral health records requested by Fallon Health, 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 applicable state and federal laws.

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There are multiple types of medical record reviews associated with Fallon and its contracted providers, which may serve different requirements as set forth in contracts with state and federal government programs or agencies. The reviews may require a random sampling of health records to be reviewed on a periodic basis and there could be some overlap depending on sample period or the scope of the review, volume of claim billed and/or other identified outliers. Fallon Health may request medical records or other appropriate records of members from providers for medical necessity (Utilization Management), appeals and grievances, claims processing, provider audits, fraud waste and abuse audits, or risk adjustment review to the extent permitted by state and federal law. Fallon Health will not pay a photocopying fee for such records.

All providers regardless if contracted or not with Fallon Health must comply with Fallon's confidentiality policies, federal law, state laws, and other licensing standards related to release of medical information. Providers are responsible for providing timely access to medical and behavioral health records for review by Fallon Health for activities including, but not limited to: coding review; chart documentation review; and for quality monitoring activities. This includes providing access to supporting documentation that may not be in the Progress Note itself, such as lab or other test results that influence clinical decision making. Upon request, a provider's medical records may also be reviewed by federal and state agencies. Providers are also required to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA) as well as applicable state and federal laws with regards to use and disclosure of behavioral, mental health, substance use disorder and other deemed "sensitive" records.

## **Medical record documentation standards**

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor their health care over time
- communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research, education as well as regulated encounter data submissions

## **Guidelines for medical record provider documentation**

- Patient's name and date of service must appear on all pages of the Progress Note.
- A unique identifier, either patient DOB, plan ID, or medical record #, should be on the first page of the Progress Note.

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- If a handwritten 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.
- Encounters documented using an Electronic Medical Record are considered to be one single document, meaning that continuation is assumed for all encounters, regardless of the number of pages.
- Each condition(s) being addressed should be documented in the medical record.
- Each diagnosis should be documented to assign an ICD-10-CM code to the highest level of specificity.
- Documentation must show that each condition was monitored, evaluated, assessed or treated (M-E-A-T) as appropriate on the date of the visit as appropriate.
- 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.
- 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.
- Medical record entries (particularly the description of each condition) must be legible, complete, dated and timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. Handwritten notes should be in blue or black ink only. The Provider’s signature, credentials and date of service must appear on the Progress Note in the medical record for each date of service; medical records that lack a date or provider signature and credentials are considered invalid.
- Regulatory agencies recognize each Progress Note is an “exclusive” or “stand alone” document.
- 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.
  - **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 relates 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.

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**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”.
- 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”
- Documentation should include only acceptable standard abbreviations and symbols as identified in Jablonski’s or Dorland’s Dictionary of Medical Acronyms & Abbreviations. The use of unofficial symbols is prohibited without proper medical record substantiation and context. Medical record documentation should exclude the following abbreviations as recommended per the Joint Commission

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"

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Do Not Use	Potential Problem	Use Instead
Trailing zero (X.0 mg)*  Lack of leading zero (.X mg)	Decimal point is missed	Write X mg  Write 0.X mg
MS          MSO <sub>4</sub> and MgSO <sub>4</sub>	Can mean morphine sulfate or magnesium sulfate       Confused for one another	Write "morphine sulfate"  Write "magnesium sulfate"

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## Retention of medical records

- **Hospitals and clinics** licensed by DPH must maintain records for at least twenty (20) years after the discharge or final treatment related to the episode of care of the patient to who it is related in accordance with state and federal laws
- **Hospitals or clinics** licensed by DMH shall maintain patient records for at least thirty (30) years after closing of the record due to discharge or death of last date of service in accordance with state and federal laws
- **Long Term Care Facilities** All clinical records of discharged patients or residents shall be completed within two weeks of discharge and filed and retained for at least five (5) years in accordance with state and federal laws
- **Ambulatory Care Facilities** The patient medical record must be maintained for a minimum of seven (7) years from the date of the last patient encounter in accordance with state and federal laws
- **Home Health Care** Clinical records are retained for five (5) years after the month of the cost report to which the records apply. It is filed with the Intermediary, unless state law stipulates a longer period of time in accordance with state and federal laws
- **Physicians** In accordance with the Massachusetts Board of Registration In Medicine, Records for adult patients must be maintained for a minimum of seven years (7) from date of last patient encounter. If a patient is a minor on the date of the last visit, then the physician must maintain the pediatric patient's records for a minimum period of either seven years (7) from the date of the last patient encounter or until the patient reaches the age of eighteen (18), whichever is the longer retention period. A retiring physician or his successor must maintain patient records for seven years from the date of the last patient encounter.

## Medicare audit and record retention requirements

Providers, and their downstream contracted entities, who contract with Fallon Health to provide services to Fallon Medicare Plus, NaviCare, and Summit Elder Care members must comply with Medicare laws, regulations, and CMS instructions. CMS requires that records be maintained for a minimum of ten (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 Fallon, or as the Secretary may deem necessary to enforce the contract between CMS and Fallon. 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 record listed above for a minimum of 10 years.

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## Medical Record Reviews

There are multiple types of medical record reviews associated with Fallon and its contracted providers, which may serve different requirements as set forth in contracts with state and federal government programs or agencies. The reviews may require a random sampling of health records to be reviewed on a periodic basis and there could be some overlap depending on sample period or the scope of the review, volume of claim billed and/or other identified outliers.

Provider services offered to Fallon members are subject to both federal and state laws. A provider's submission of a claim for payment also constitutes the provider's representation that the claim is submitted in compliance with all federal and state laws and regulations. Fallon Health reserves the right to recover claims payments that are contrary to national and industry standards or do not have the required minimum documentation in the provider records.

Some record reviews are further explained below.

### Medical Necessity Review:

"Medical necessity" or "medically necessary" health care services cover services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of an individual's medical condition while also meeting accepted standards of professional medical practice. Certain designated clinical teams are responsible to confirm that a service or supply is consistent with generally accepted principles of professional medical practice, as determined by whether or not: (1) the service is the most appropriate available supply or level of service for the member in question, considering potential benefits and harms to the individual; (2) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (3) for services and interventions not in widespread use, is based on scientific evidence.

### In-Depth Medical Record Review:

In-depth Medical Record Reviews are a part of the Payment Integrity Program at Fallon. A Payment Integrity Program is a requirement of federal and state regulations. In addition, the Centers for Medicare and Medicaid Services (CMS) require a formal fraud, waste and abuse (FWA) compliance program. Fallon contracted with a partner to conduct FWA reviews. Fallon Health payment reviews are conducted in accordance with the Centers for Medicare & Medicaid Services (CMS) and state insurance department requirements that obligate Fallon Health to monitor provider claims billing. These claims billing audits are conducted as part of Fallon Health's FWA (compliance and program integrity) activities. An FWA audit is focused on reviewing the claims billed by the provider and determining if the documentation in the member's medical record supports the billing of the claim.

As such, Fallon is required to conduct post payment reviews of medical records for adherence to medical policies, American Medical Association (AMA) guidelines, and compliance adopted documentation standards consistent with those of the CMS, which state that medical records must contain information to justify treatment, admission or

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continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. In accordance with federal regulations and AMA guidelines, the documentation within the patient's medical record must meet the components of the services billed.

## **Risk adjustment overview**

Risk Adjustment is a payment mechanism based on patient medical status. A risk score is assigned to patients largely based on reported ICD10-CM diagnoses reported through Encounter data (professional 837P, facility 837I; professional CMS 1500 and facility UB04). Other relevant data elements that can comprise a risk score include:

- gender & age
- socioeconomic status (duals)
- insurance status (metallic tier)
- procedure codes
- special patient-specific conditions (end-stage renal disease)

For providers, risk adjustment is fundamentally the process of documenting and coding face to face visits accurately to describe each patient diagnostically and completely as possible describing a patient diagnostically as completely as possible in the medical record note(s).

For providers, the most relevant aspect of the risk adjustment process is to accurately and completely describe each patient diagnostically. 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 claims and encounter 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).

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- 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).

## **Important Reminders for Risk Adjustment**

- 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.
- Certain “health status” codes are very important to risk-adjustment. Examples include but are not limited to; lower limb amputation status, and Ostromies (specify type).
- Source: [http://www.jointcommission.org/standards\\_information/npsgs.aspx](http://www.jointcommission.org/standards_information/npsgs.aspx)