Medical and behavioral health records

Medical and behavioral health records

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 Weinberg requires providers to comply with all statutory and regulatory requirements applicable to Member medical records, including, but not limited to those contained in New York Codes, Rules and Regulations Title 10 Section 405.10, and any amendments there to.
Fallon Health Weinberg requires that medical and behavioral health records must contain information to identify the Member, the date of encounter, justify treatment, admission, or continued hospitalization, support the diagnosis, and describe the patient's progress, responses, and outcomes to medications and services.

Providers must be consistent with current and nationally accepted professional standards for providing the treatment/services, as well as systems for accurately documenting the following: Member information, including primary language spoken; clinical information and assessments; pharmacy records; treatment plans, services provided, goals and outcomes; as well as contacts with the Member's family, guardians, or significant others; and all contacts with state agencies, as applicable. Members have the right to access and correct their health information.

Medical and behavioral health records must be confidentially maintained in a manner that is current, detailed, and organized and permits effective patient care, utilization review, and quality reviews. Providers are responsible for maintaining medical and behavioral health records for Fallon Health Weinberg 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 amendments to or 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 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 Weinberg, members, or other clinicians to ensure continuity and coordination of care, including but not limited to behavioral health treatment of members who express suicidal or homicidal ideation or intent, consistent with applicable state and federal laws.

Medical and behavioral health 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

All Member medical records, whether paper or electronic shall, at a minimum, be consistent with commonly accepted standards for medical record documentation, as follows:

1) Each page in the record or progress note must contain the patient's name or ID number, and date of service
2) The first page of the progress note should contain a unique identifier, either patient DOB, plan ID, or medical record #.
    - 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.
3) Include, personal biographical data the address, home telephone, mobile telephone, and work telephone numbers, name of employer, marital status, primary language spoken, and any disabilities, such as visually impaired, hearing impaired, uses a wheelchair.
    - Include documentation of additional voluntary demographic information collected directly from the patient including race, ethnicity, gender identity and sexual orientation.
4) An immunization record (for children) that is up to date, or an appropriate history has been made in the medical record (for adults).
5) Each condition(s) being addressed should be documented in the medical record.
6) Each diagnosis should be documented to assign an ICD-10-CM code to the highest level of specificity.

Medical and behavioral health records

7) Documentation must show that each condition was monitored, evaluated, assessed, or treated (M-E-A-T) as appropriate on the date of the visit. 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) Documentation to include any unresolved problems from previous office visits are addressed in subsequent visits.
9) Documentation to include significant illnesses and medical conditions are indicated on the problem list.
10) 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.
11) Past medical history must be easily identified and includes serious accidents, operations, and illnesses. For children and adolescents, past medical history relates to prenatal care, birth, operations, and childhood illnesses.
12) Presence of current medication list.
13) Documentation must include medication allergies and adverse reactions; and be noted if the patient has no known allergies or history of adverse reactions.
14) Include there is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
15) For children, adolescents and adults, there is appropriate notation concerning:
    - the use of cigarettes, alcohol and substances.
    - and under or over-utilization of specialty services or pharmaceuticals**.**
16) Documentation must include there is evidence that preventive screening and services are offered in accordance with the EPSDT Periodicity Schedule or, for individuals over age 21, the Provider’s own practice guidelines, including the administration of behavioral health screenings.
17) Medical record entries (particularly the description of each condition) must be legible to someone other than the writer, 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, or the provider’s credentials are considered invalid.
18) All entries in the medical record contain the author’s identification. Author identification may be a handwritten signature, unique electronic identifier, or initials.

Medical and behavioral health records

19) Medical record entries (particularly the consultation, laboratory and imaging reports) filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
20) Documentation must show that Laboratory and other studies are ordered, as appropriate.
21) Working diagnoses are consistent with findings.
22) Treatment plans are consistent with diagnoses.
23) 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.
24) Primary care providers document all services provided directly and all ancillary and diagnostic tests that are ordered by the practitioner.
25) If a consultation is requested, there is a note from the specialist in the record.
26) Referrals to diagnostic and therapeutic services for which a member was referred, such as home health nursing, specialty physician, hospital discharge and physical therapy reports should be included in the record.
27) Regulatory agencies recognize each Progress Note is an “exclusive” or “stand alone” document.
28) 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.

Medical and behavioral health records

For records pertaining to inpatient hospital services and inpatient services in mental hospitals: Providers must include the following information as set forth in 42 CFR 456.111

1) Identification of the Member.
2) The name of the Member's physician.
3) Date of admission,
4) The plan of care required under 42 CFR 456, et seq.
5) Initial and subsequent continued stay review dates described under 42 CFR 456.128 and 456.133.
6) Reason and plan for continued stay if the attending physician believes continued stay is necessary.
7) Other supporting material that Utilization Management believes appropriate to be included in the record, e.g., labs, scans, medical social service records, specialist assessment and treatment plans, ED notes, Case management/ social service notes for discharge planning, consults (specialist assessments), possibly Emergency Medical Treatment and Labor Act (EMTALA) forms if the Member is being transferred.

Additionally, Inpatient hospital services must also include:

8) Date of operating room reservation, if possible.
9) Justification of emergency admission, if applicable.

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"

Medical and behavioral health records

- 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”

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_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write “morphine sulfate” Write “magnesium sulfate”

Medical and behavioral health records

Retention of medical records

Providers of all types are responsible for understanding their retention rules as set forth by the state of NY and abiding by such timeframes. Records must be maintained in a HIPAA compliant manner, with adequate policies to prevent unallowable access use or disclosure.

Medicare audit and record retention requirements

Providers, and their downstream contracted entities, who contract with Fallon Health Weinberg to provide services to Fallon Health Weinberg 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 Health Weinberg, or as the Secretary may deem necessary to enforce the contract between CMS and Fallon Health Weinberg. 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 members. Therefore, it is crucial that providers retain the types of record listed above for a minimum of 10 years.

Medical Record Reviews

There are multiple types of medical record reviews associated with Fallon Health Weinberg 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 Weinberg 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 Weinberg will not pay a photocopying fee for such records.

All providers regardless of contract status with Fallon Health Weinberg must comply with Fallon Health Weinberg'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 Weinberg 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.

Provider services offered to Fallon Health Weinberg 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 Weinberg 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 Health Weinberg. 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 Health Weinberg contracted with a partner to conduct FWA reviews. Fallon Health Weinberg payment reviews are conducted in accordance with the Centers for Medicare & Medicaid Services (CMS) and state insurance department requirements that obligate Fallon Health Weinberg to monitor provider claims billing. These claims billing audits are conducted as part of Fallon Health Weinberg’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 Health Weinberg 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 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 patients' full picture of diagnosis, as specifically and completely as possible at time of each encounter.

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 a member. 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

- Fallon Health Weinberg requires providers to submit complete and accurate claims.
- 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).
- An additional internal oversight of submitted diagnosis codes is conducted retrospectively 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.

Medical and behavioral health records

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).

- 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 member 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).
- 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 reset for risk-adjustment every year on December 31st. Therefore, providers must document all chronic conditions and diagnoses that impact patient health care, and are being 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 Ostomies (specific type must be documented).
- Acute complications such as ostomy/catheter infections, leaks, or other malfunctions should be seen face-to-face and documented thoroughly during active complication.
- Each encounter is a stand-alone document. For example, one encounter may not refer to another encounter for more information. All pertinent documentation must exist within each encounter.
- Source: https://www.jointcommission.org/standards