Medical and Behavioral Health Records: Documentation Standards and Record Keeping Practices

Fallon Health Weinberg (FHW) 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 Weinberg are responsible for maintaining medical and behavioral health records for FHW 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 New York state law.

Physicians/Providers contracted with FHW must comply with FHW'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

- FHW 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.

- **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).

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

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.

Medical and Behavioral Health records documentation standards, audit and record keeping practices

Fallon Health Weinberg 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.

Practitioners contracted with Fallon Health Weinberg are responsible for maintaining medical and behavioral health records for FHW members in an organized medical and behavioral health record keeping system. Contracted practitioners must release in a timely manner copies of medical 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 state law.

Practitioners contracted with FHW must comply with FHW's confidentiality policies related to release of medical information. Physicians are responsible for providing access of medical and behavioral health records for review by the health plan clinical staff for quality monitoring activities. Reviews of physician's medical and behavioral health records are routinely conducted with feedback to the contracted physicians.

Guidelines for Medical Records

1. Each page in the record contains the patient's name or Medical Record Number.
2. Personal biographical data include the address, employer, home and telephone numbers and marital status.
3. Entries in the medical record contain the author's identification by handwritten or electronic signature and date of service.
4. Primary care providers document all services provided directly and all ancillary and diagnostic tests that are ordered by the practitioner.
5. 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.
6. The record is legible to someone other than the writer.
7. Significant illnesses and medical conditions are indicated on the problem list.
8. Medication allergies and adverse reactions are prominently noted in the record. If the member or patient has known allergies or history of adverse reactions, it is

appropriately noted in the record.

9. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger) past medical history relates to prenatal care, birth, operations and childhood illnesses (when applicable to patients or plan).
10. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (when applicable to patients or plan).
11. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
12. Laboratory and other studies are ordered, as appropriate.
13. Working diagnoses are consistent with findings.
14. Treatment plans are consistent with diagnoses.
15. Encounter forms or notes have a notation, when indicated, regarding follow up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
16. Unresolved problems from previous office visits are addressed in subsequent visits.
17. The ordering practitioner signs consultation, lab and imaging reports filed in the chart to validate review of information.
18. Members are not placed at inappropriate risk by a diagnostic or therapeutic procedure.
19. Immunization records for children are current and complete according to the Pediatric preventive guidelines.
20. Evidence that preventive screening and services are offered to all members in accordance with the organization's practice guidelines.
21. Documentation of advance directives should be included in a prominent part of the medical record, including whether or not a member has executed an advance directive.
22. Presence of current medication list.

Guidelines for Behavioral Health Records

1. Record is legible
2. Consumer name or ID no. noted on each page of record
3. Entries are dated & signed by appropriately credentialed provider

4. Record contains relevant demographic info including address, employer/school, phone, emergency contact, marital status
5. Treatment consent form signed or refusal documented
6. Patient Bill of Rights signed or refusal documented
7. Psych advance directives or refusal documented
8. Informed consent for meds signed or refusal documented
9. Release(s) for communication w/PCP, other providers and involved parties are signed or patient refusal documented
10. Reason member is seeking services (presenting problem) & mental health exam
11. DSM diagnosis (5 axis)
12. History & symptomology consistent w/DSM-IV criteria
13. Psychiatric history
14. Co-occurring (co-morbid) substance induced disorder assessed
15. Current and past suicide/danger risk assessed
16. Assess of consumer strengths, skills, abilities, motivation etc.
17. Level of familial/supports assessed and involved as indicated
18. Consumer ID'd areas for improvement/outcomes documented
19. Medical history
20. Exploration of allergies and adverse reactions
21. All current medications w/dosages
22. Discussion of d/c planning/linkage to next level
23. Individualized strengths-based treatment plan is current
24. Measurable goals/objectives documented
25. Goals/objectives have timeframes for achievement
26. Goals/objectives align w/consumer identified areas for improvement/outcomes
27. Preventive/ancillary services incl. community & peer supports considered
28. Crisis plan documented
29. Documentation substantiates treatment at the current intensity of support (level of care)
30. Progress towards measurable consumer identified goals & outcomes evidenced. If not, barriers are being addressed
31. Clinical assessments & interventions evaluated at each visit
32. Complete substance use assessment is current/ongoing
33. Suicide/risk assessment is current/ongoing
34. Medications are current
35. Evidence of treatment being provided in a culturally competent manner
36. Family/support systems contacted/involved as appropriate/feasible
37. Ancillary/preventive services considered, used & coordinated as indicated

38. Discharge planning/linkage to alternative treatment (level of care) leading to discharge occurring
39. For minors only: Guardianship information noted
40. For minors only: Developmental history for children and adolescents
41. For those w/a substance use d/o only: Evidence of Medication Assisted Treatment and/or discussion present
42. Records are stored securely
43. Only authorized personnel have access to records
44. Staff receive periodic training in confidentiality of member information
45. Treatment records are organized & stored to allow easy retrieval
46. Treatment records are stored in a secured manner that allows access by authorized personnel only

Results of medical and behavioral health record review audits are shared with practitioners at the Site director's meetings, provider newsletters or direct mailings. FHW's performance goal for Medical and Behavioral Health Record keeping compliance to the standards is
100%. Chart availability of the medical and behavioral health records also has a performance goal of 100%.

The Quality and Health Services Department is responsible for monitoring medical and behavioral health record keeping regarding documentation standards, and reviewing the data analysis of aggregate findings to identify key processes to improve as requested. The medical and behavioral health record audit tool is used to review clinical records to determine compliance with critical elements of the medical and behavioral health record. Findings of the record reviews are presented to the Clinical Quality Improvement
Committee for the assessment of the quality of the clinical records and if needed, corrective action and targeted interventions for improved record-keeping practices.