Medical Records

Effective Date: 10/19/2017 Draft/Review Date: 10/19/2017

Policy

A. It is the policy of the ACO to ensure that Participants, Providers/Suppliers, and other individuals or entities performing functions or services related to the ACO's activities maintain a medical/health record for every Beneficiary that includes the Beneficiary's health and case history and proper identification. The medical record meets all requirements for the ACO, including applicable federal and state laws.

Applicability

This policy and procedure applies to all Participants, Providers/Suppliers, and other individuals or entities performing functions or services related to the ACO's activities.

Procedure

A. Medical record documentation includes clinical assessments as well as services provided to Beneficiaries. The record shall meet CMS guidelines, professional standards, privacy standards, and any applicable federal and state laws and regulations.

B. **Medical Record Contents**

The medical record shall include all metrics necessary to report ACO quality measures. Best efforts shall be made to ensure the medical record includes the following general areas and that information is added to each section chronologically.

1. Demographics, examples include but are not limited to:
    a. Name, addresses, contact numbers, and e-mail\Emergency contacts.
2. Assessments, examples include but are not limited to:
    a. Vital signs;
    b. Wellness assessments;
    c. Clinical assessments; and,
    d. Behavioral health.
3. Medical History, examples include but are not limited to:
    a. Allergies;
    b. Habits & Risk Factors;
    c. Immunizations; and,
    d. Past illnesses.
4. Orders and Prescriptions, examples include but are not limited to:

a. Current medication list; and,

b. Prescriptive orders – amount, frequency, dose & number of cells.

5. Medical Encounters, examples include but are not limited to:

   a. Individual encounters with summaries of visits, care and consultation; and,

   b. Encounters from other settings such as hospitalizations or specialty providers' reports should be maintained in the medial record.

6. Progress Notes, examples include but are not limited to:

   a. Response to treatment; and,

   b. Compliance.

7. Test Results, examples include but are not limited to:

   a. Blood/lab tests;

   b. X-rays or x-ray reports; and,

   c. Other tests (such as pulmonary function, biopsy results, etc.).

C. **Maintenance and Legibility of Records**

1. All medical records regardless of form or format must be maintained in their entirety, and no document or entry may be deleted from the record, except in accordance with the Record Retention Requirements policy.
2. Handwritten entries should be made with permanent blue or black ink. This is to ensure the quality of electronic scanning, photocopying and faxing of the document.
3. All entries must be legible to individuals other than the author.
4. Corrections and Amendments to Records

   a. When an error is made in a medical entry, the original entry must not be deleted and the inaccurate information should still be accessible.

   b. The correction must indicate the reason for correction, be dated and signed by the person making the revision and the corrected data entered.

   c. Paper record amendments

      i. Do not place labels over the entry to correct the information.

      ii. Draw a line through the incorrect entry and annotate the record with reason, date and signature.

      iii. If already scanned, reprint, make corrections and rescan the document.

   d. Electronic amendments

      i. Add an addendum to the electronic document indicating the corrected information, the identity of the individual creating the addendum, and the electronic signature.

ii. Preliminary versions of transcribed documents may be edited by the author prior to signing. A transcription analyst may also make changes when a non-clinical error is found prior to signing (Wrong work type, wrong date).

iii. Once a transcribed document is final it can only be corrected using an addendum affixed to the final copy.

iv. Documents may need to be moved or re-created in the case of a wrong work type or indexed to the wrong Beneficiary record.

e. Late Entries

i. When an entry is not made in a timely manner or was missed, this can be corrected by identifying a "late entry".

ii. Enter current date and time. Identify the date/time of the original event or circumstance and create the note.

iii. An addendum is a kind of late entry that allows the author to provide additional information or corrections to original entries. These should be written as soon as possible after the original note.

D. **Coding and Billing**

1. The medical record should contain information that supports billing on insurance claim forms.
2. Training will be provided to ensure proper documentation and proper coding for reimbursement.
3. Healthcare providers may designate the billing code on an encounter form. In other cases, billing codes may be assigned by trained coding staff using current coding sets and standards.
4. Encounter forms will be sent to the billing office. Billing and coding staff will confirm the appropriate codes prior to submitting the bill. Staff will also ensure that the Health Insurance Portability and Accountability Act (HIPAA) standards for billing transactions are met.

E. **Completion, Timeliness and Authentication of Beneficiary Records**

1. All medical record entries are to be dated, the time entered and signed in a timely manner or per law.
2. Parts of the medical record that are the responsibility of the physician must be authenticated by that physician. Non-physician data collection and information gathering shall be authenticated by the physician.
3. Electronic methods of authentication such as passwords, access codes, computer keys, or key cards may be allowed provided certain requirements are met. Computer codes and written signatures must be readily available and maintained under adequate safeguards.

4. Specific action is required to authenticate electronic medical records:
    a. The physician may review online documentation and verify by entering a computer code.
    b. A system where the physician signs off against a list of entries must be verified in the individual record.
5. Fax signatures are acceptable.
6. When rubber stamps are used, there is no delegation to another individual.
7. Sanctions should be in place for improper or unauthorized use of stamp, computer key or other code signatures.

F. Quality performance will be reviewed by CMS using audits to validate data submitted by the ACO related to the Medicare Shared Savings Program.

Reporting

A. N/A

Related Documentation

A. 42 CFR § 425.314, §425.500, §425.504(a)(2)(ii), §425.506, §425.706
B. ACO Terms & Definitions Policy
C. Beneficiary Rosters Policy
D. Privacy & Security of Beneficiary Data Policy
E. Provider Access & Availability Policy
F. Record Retention Requirements Policy

Additional Guidance

CMS Medicare Learning Network: Evaluation and Management Services Guide December 2010/ICN: 006764.

EHR Incentive Program: Eligible Professional Meaningful Use Table of Contents Core and Menu Set Objectives.

CHLN.org – ICD Coding Compliance.

Some procedures to intermittently audit records to assess meeting the standards for the Medicare Shared Savings Program are recommended. Self-audit can assist practices in ensuring compliance to the CMS regulations. The regulation around CMS audits is the following:

A. A*udit and validation of data*

CMS retains the right to audit and validate quality data reported by an ACO.

1. In an audit, the ACO will provide Beneficiary medical records data if requested by CMS.
2. The audit will consist of three phases of medical record review.
3. If, at the conclusion of the third audit process there is a discrepancy greater than 10 percent between the quality data reported and the medical records provided, the ACO will not be given credit for meeting the quality target for any measures for which this mismatch rate exists.