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ACTION

- New Policy
- Repealed Policy Date: _____
- Superseded Policy Number: _____

POLICY:

It is the policy of Johns Hopkins HealthCare LLC (JHHC) to ensure that Plan Members’ medical record documentation is maintained in a manner that is current, detailed, organized, promotes effective and confidential patient care and quality review, and meets established goals for medical record keeping.

SCOPE:

This policy applies to contracted and non-contracted providers providing services and goods to Plan Members.

ABBREVIATIONS:


- CMS** – Department Health and Human Services Centers for Medicare and Medicaid Services
- COMAR** – Code of Maryland Annotated Regulations
- HEDIS** – Healthcare Effectiveness Data and Information Set
- HIPAA** – Health Insurance Portability and Accountability Act of 1996
- NCQA** – National Committee for Quality Assurance

DEFINITIONS

All Lines of Business for the purpose of this policy refers to the following entities Priority Partners MCO, Employer Health Programs, US Family Health Plan, Hopkins ElderPlus, and Hopkins Health Advantage, Inc.’s Medicare Advantage and other commercial insurance plans.

Attestation Statement is a statement that must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.

Authentication or Authenticated is the establishment of the identity of the author of a medical record entry. Authorship may be shown by a signature, electronic signature, countersignature (requires professional review and signifies approval of action taken by

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another provider), signature stamp (only if an Attestation Statement is provided at time of medical record request), or electronic/digital signature. The purpose of the appending the signature (counter, digital, electronic, handwritten or stamped) is to certify that the services submitted to the Plan have been accurately and fully documented, reviewed and authenticated. The signature also attests to the medical necessity and reasonableness of the service submitted to the Plan for payment consideration.

Authorship is attributed to a specific individual or entity acting at a particular time. Authors are responsible for the completeness and accuracy of their entries in the health record.

Digital signature is a handwritten signature on a pen pad. The handwritten signature is then converted into an electronic image.

Electronic Signature is a signature that computer software binds to a specific electronic document. It requires the user authentication such as a unique code, biometric or password that verifies the identity of the signer in the system.

Handwritten signature is a mark or sign by an individual on a document to signify that the services submitted to the Plan have been accurately and fully documented, reviewed and authenticated.


Medical record is a confidential written or electronic document that details the medical care provided to a Plan Member.

Signature Date is the date on which the service was performed or ordered. If the entry immediately above or below the entry is dated, medical review may reasonably assume the date of the entry in question.¹

Signature Log is the documentation that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document.

Stamped Signature is a signature on a rubber stamp. The purpose of the stamped signature is to certify that the services submitted to the Plan have been accurately and fully documented, reviewed and authenticated. When the provider uses a Signature Stamp, he/she must place a

¹ http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

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signed statement in the medical record stating that he/she is the only authorized user of said stamp.²³ There may be no delegation of the stamp to another user.

PROCEDURE & RESPONSIBILITIES:

Provider records are required to meet the following medical record documentation requirements.

Complete electronic or hardcopy medical records are to be maintained, stored, and retained in a manner which protects the safety and confidentiality of the Plan Members’ information in accordance with Federal and State laws, accreditation requirements and accepted professional practice standards.


Providers will provide periodic confidentiality and protection of patient protected health information training to their staff.

A medical record is considered to be complete if it contains sufficient information to identify the patient, support the diagnoses/condition; justify the care, treatment and services; document the course and results of care, treatment and services; and allow for continuity of care among providers. An individual entry into the medical record must contain sufficient information on the matter that is the subject of the entry to permit the medical record to satisfy the completeness standard. Documentation must be accurate, appropriate, and individualized to the specific patient. Providers are required to follow guidance supplied by the Plan as well as nationally recognized coding conventions appending appropriate diagnosis (ICD9CM/ICD10) and/or procedure/service code assignment (Current Procedural Terminology {CPT} Healthcare Common Procedure Coding System {HCPCS}) as supported by medical record documentation.

Plan Member medical records are to be stored in an organized record keeping system in chronological order so that they are easily retrievable and reproducible for audit and inspection by the Plan and/or appropriate state and/or federal regulatory bodies. All providers with electronic medical records will maintain or have the ability to generate a legible copy of the record in order to comply with patient, Plan or governmental requests and maintain a back-up copy of the electronic medical record.

² TRICARE Policy Manual Chapter 1 Section 5.1 Subsection 3.8

³ CMS does not approve the use of signature stamps on any medical record. MLN SE 0829 (related change request number 5971/Transmittal 248) issued July 6, 2013, Chapter 3.3 Section 2.4 of the Medicare Program Integrity Manual.

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Upon request, provider's medical records must be available for utilization and quality improvement review studies, retrospective review of claims and audits, as well as Plan's and regulatory agencies' requests and Member relations inquiries. Examples of Plan audits include but are not limited to:

1. Compliance investigations/audits,
2. Complaint and Grievance investigations,
3. Appeals reviews,
4. Quality of care/Patient safety investigations, and
5. HEDIS (Health Care Effectiveness Data Information Set) reviews.


Listed below are some recommended methods by which records containing PHI may be submitted to the Plan.

1. Sent by USPS using a trackable method,
2. Password protected CD/DVD sent by a trackable method,
3. Secure FTP or FTA or other designated secure submission portal,
4. Hand delivered, or
5. Emailed using encrypted email

All services/goods (claims) billed by or on behalf of a provider for reimbursement are subject to Plan review and must be supported by complete documentation in the medical record. Documentation must support the intensity of the service provided to the Plan Member including the thought process and complexity of the provider's medical decision-making.

Failure of provider to follow applicable state and federal laws and regulations, the Medical Record Documentation Standards or failure to produce the requested medical record for Plan audit will result in retraction of reimbursed services as the care/service cannot be substantiated and, in appropriate circumstances, may result in the termination of the contracted providers' contracts with the Plan.

The HIPAA Privacy Rule permits a provider to disclose protected health information for: quality related "health care operations" of the health plan, provided that the health plan has or had a relationship with the individual who is the subject of the information, and protected health information requested pertains to the relationship. See 45 CFR 164.506(c)(4). Thus a provider may disclose protected health information to the health plan for the plan's Healthcare Effectiveness Data and Information Set (HEDIS) and audit purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan. "Health care operations" includes care management, utilization review activities, and similar activities. See 45 CFR 164.501 (definition of "health care operations").

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Providers are required to retain and/or destroy medical records (or copies thereof) in accordance with applicable Federal and State law.

In accordance with CMS guidance, ALL Medicare Advantage documents are to be retained for a minimum of ten (10) years.

Annually, Plan Members are entitled, at no cost to the Member, one copy of his or her medical record.

All medical record entries are required to be:

1. Dated,
2. Authenticated⁴,
3. Legible to someone other than the writer,
4. Identifiable, and
5. Support all codes submitted

Documentation must be, individualized, pertinent, detailed, and support the level of care and service billed. Each page of the medical record must contain a patient identifier (either name or medical record number). All records must contain the author's identification. Author identification may be a handwritten or electronic signature. Initials may be used only if a signature page is provided which identifies the initials to the signature.


Documentation must be presented in a standard format that allows the reader, other than the author, to review and comprehend the content without use of separate legend/key.

Medical record elements shall include but are not limited to the following:⁵


1. Biographical information
2. History and Physical (subjective (e.g. chief complaint) and objective (includes medical decision-making) including but not limited to:
 - a. Reason for encounter.
 - b. *Past History (PMH) - for patients seen three or more times is easily identified and includes serious accidents, operations, illness. For children and adolescents (18 or younger), PMH relates to prenatal care, birth, operations and childhood illnesses.*

⁴For the Plan to consider a signature stamp to be valid, the provider must append a note within the medical record documentation annotating that he or she is the only authorized user of the said stamp.

⁵ Asterisk (*) NCQA Core Components

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- c. Social History - For children age 12 or older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances. For all persons (12 or older) substance abuse history is to be queried.
- d. Family History
- e. * Allergies and Adverse Reactions – a listing of all known allergies (including medication) and adverse reactions must be prominently annotated in the record.*
- f. Immunization record- (for children) is up to date or an appropriate history has been made in the medical record (for adults)
- g. Health risk factors
- h. Working diagnosis (consistent with findings)
3. * Individualized current problem list (including all significant illnesses and medical conditions)*
4. Current medication list (including dosage, frequency, and route)
5. Evidence of review and addressing of unresolved problems from previous visits.
6. Response to therapy/ Patient progress
7. Evidence of care coordination
8. Consultations/Referrals filed in the record must demonstrate the medical necessity for the service and/or test ordered. If a consultation was requested it is expected that the consultant's report is present in the record and the record demonstrates evidence of review of the results by the provider who ordered the service. Consultations and abnormal laboratory and/or imaging results have an explicit notation in the record including follow-up plan of action.
9. Laboratory/Diagnostic testing – this includes documentation to support the medical necessity for the tests ordered as well as provider review of the test results, member notification of positive findings, and appropriate follow-up.
- 10.*Documentation must reflect that there is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.*
- 11.Evidence that preventative services and risk screening are offered in accordance with JHHC's practice guidelines.*
- 12.Evidence of care coordination within the practice
- 13.*Individualized treatment plan consistent with diagnoses*
- 14.*Working diagnosis must be consistent with findings*
- 15.Documentation of a start and stop time when a time based code is used
- 16.Patient/family instructions/education
 - a. Age appropriate anticipatory guidance
 - b. Instructions for follow-up.
- 17.Annotation of whether the member has an Advanced Directive or not.

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Electronic records offer many benefits such as legibility and efficiencies in communication. As with its hardcopy counterpart, electronic medical records (EMR) documentation must accurately support the service/good billed to the Plan. Documentation short cuts may create problems with determining: (1) the individuality of the care rendered, (2) the medical necessity of the care or service rendered, and (3) the complexity of the service billed. Use of a boiler plate or pre-prepared text template, requires provider vigilance to ensure that the documentation accurately reflects the services/care provided. Failure to do so may result in errant billed practices and denial or recoupment of claims payments.


Use of cut, copy and paste or cloned functionality not only raises the question of authorship but also whether or not the service actually occurred. Risks of cloned notes include populating records with inaccurate, incomplete, inconsistent, and/or outdated information.

Therefore, providers must review their notes for accuracy and relevance prior to appending either their hardcopy or electronic signatures.

Late entry notes must always be identified as such. The late note should be dated with the current date and time that the note was written and not backdated to the intended date of the original note. Late entry notes must be authenticated in the same manner as all other notes.

CROSS REFERENCE:

- Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, effective January 2013 (COMAR 10.09.02) - https://mmcp.dhmh.maryland.gov/docs/Phys-svcs-prov-fee-man_2013.pdf
- Medicare Managed Care Manual
- TRICARE Policy Manual Chapter 1 Section 5.1 – Requirements for Documentation in Medical Records
- Department of Health and Human Services Office of Inspector General 2013 Work Plan pg. 25 http://oig.hhs.gov/reports-and-publications/archives/workplan/2013/WP01-Mcare_A+B.pdf
- Department of Health and Human Services Office of Inspector General 2011 Work Plan pg 14 http://oig.hhs.gov/publications/workplan/2011/FY11_WorkPlan-All.pdf
- Complying with Medicare Signature Requirements , August 2012 - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf
- Change Request 5971 Clarification – Signature Requirements MLN SE 0829 (related change request number 5971/Transmittal 248/MM 8219) issued July 6, 2013

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- Chapter 3.3.2 Medical Review Guidance Section 2.4 Signature Requirements of the Medicare Program Integrity Manual located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf>
- NCQA Medical Record Standards