MEDICAL RECORDS REQUESTS AND SUBMISSION OF ENCOUNTER DATA

MASS ADVANTAGE
A Medicare Advantage Plan

CONFIDENTIALITY AND GENERAL CONSENT

Confidentiality of patient information is important to Mass Advantage. Any information disclosed by you in response to medical record requests will be treated in accordance with applicable privacy laws. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. § 164.502, you are permitted to disclose the requested data for purpose of treatment, payment and health care operations without additional member consent.

Mass Advantage has the right to request medical records for medical necessity review, during HEDIS projects and risk adjustment data submission to CMS. Please refer to your Mass Advantage provider agreement for further information. Providers may receive requests from Mass Advantage, directly or through its preferred vendor, for medical records with specific dates of service for review. Medical records can be mailed, faxed, securely e-mailed, or sent securely via SFTP with prior approval.

In accordance with 42 C.F.R. 422.2480 (c), providers, including first-tier and downstream entities, must maintain all records containing data used by Mass Advantage to calculate Medicare Medical Loss Ratio (MLR) for Medicare Advantage plans and/or evidence needed to validate MLRs ("MLR Records") for 10 years.

ENCOUNTER DATA SUBMISSION

Each Medicare Advantage Organization ("MAO") must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, or other practitioner. Information pertaining to services provided must be submitted by the MAO for all of the services provided by the network and non-network providers.

Encounter data shall conform with and include all information necessary for the MAO to submit data to CMS in accordance with applicable CMS and federal requirements, including but not limited to all HIPAA requirements that may be imposed upon a MAO and provider. If the provider fails to submit encounter data accurately, completely, and truthfully, in the format described in 42 C.F.R. § 422.257, then this will result in denials and/or delays in payment of the provider's claims.

In addition, the provider has contractually agreed to certify the accuracy, completeness and truthfulness of the provider's generated encounter data that the MAO is obligated to submit to CMS no later than 30 days after the beginning of every fiscal year while the Medicare Advantage participation is in effect. This certification shall be provided in writing and in the specified format at the request of the MAO.

Encounter data can be submitted on a paper claim format or through Electronic Data Interface (EDI) following the same rules as submitting claims. These service become an integral part of Mass Advantage's claims history database and are used for analysis and reporting.

ENCOUNTER DATA REPORTING

Mass Advantage will accept encounter data via hard copy (CMS-1500 or UB-04) or electronically (in specified formats). Electronic encounter data is due to Mass Advantage by the fifth day of the second month following the encounter.

ENCOUNTER DATA FOR RISK ADJUSTMENT PURPOSES

Risk adjustment is the process by which CMS reimburses Medicare Advantage plans for the health status and demographic characteristics of their enrollees. CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-10-CM codes) and encounter data submitted to Medicare Advantage plans to establish risk scores. The primary source of encounter data or ICD-10-CM codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review.

CMS looks to providers to code identified conditions accurately using ICD-10-CM coding guidelines with supporting documentation in their medical record.

The provider's role in risk adjustment includes:

- Accurately reporting ICD-10-CM diagnosis codes to the highest level of specificity (critical as this determines disease severity).
- Documentation should be complete, clear, concise, consistent, and legible.
- Documentation of all conditions treated or monitored at the time of the visit in support of the reported diagnosis codes.
- Use of standard abbreviations.
- Notifying Mass Advantage of any erroneous data submitted and following the appropriate procedures to correct erroneous data.
- Submitting claims in a timely manner, generally within thirty (30) days of the date of service (or discharge for hospital inpatient admissions).
- Maintain all records containing data used by Mass Advantage to calculate Medicare MLRs.

RISK ADJUSTMENT DATA VALIDATION (RADV) AUDITS CONDUCTED BY CMS

Annually, CMS selects (both random and targeted) Medicare Advantage plans for a data validation audit. CMS utilizes medical records to validate the accuracy of risk adjustment diagnoses submitted by the Medicare Advantage plans. The medical record review process includes confirming that appropriate diagnosis codes and level of specificity were used,

verifying the date of services is within the data collection period, and ensuring the provider's signature and credentials are present. If CMS identifies discrepancies and/or confirms there is not adequate documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments will be imposed.

ICD-10 CM CODES

CMS requires that providers currently use the ICD-10 CM Codes (ICD-10 Codes) and coding practices for Medicare Advantage business. In all cases, the medical record documentation must support the ICD-10 Codes selected and substantiate that proper coding guidelines were followed by the provider. For example, in accordance with guidelines, it is important for providers to code all conditions that co-exist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the provider code to the highest level of specificity, which includes fully documenting the patient's diagnosis.

DOCUMENTATION TIPS FOR MEETING CMS REQUIREMENTS FOR SUBMISSION OF ENCOUNTER DATA AND RADV AUDITS

Progress Note Requirements:

- Progress notes must contain patient name and dates of service on each page.
- If the progress note is more than one page or two-sided, the pages must be numbered, (i.e., 1 of 2). If pages are not numbered, then the Provider must sign each page of the progress note.
- Progress notes should follow the standard Subjective, Objective, Assessment, and Plan (S.O.A.P.) format

Provider Signature Requirements on Progress Note:

- All progress notes must be signed by the Provider rendering services.
- Provider credentials must either be pre-printed on the progress notes as a stationary or the provider must sign all progress notes with his/her credentials as part of the signature.
- Dictated notes and consults must be signed by the provider.
- Provider signature must be legible, i.e., "John Smith Doe, M.D." or "JSD, MD." If a provider's signature is illegible, a signature log must be completed.
- Stamped signatures are no longer acceptable for provider documents as of April 28, 2008, as stated by CMS (Medicare Program Integrity Manual, Transmittal 248, Change Request 5971.5550). For risk adjustment purposes (Part C), signature stamps will no longer be acceptable on medical records with dates of service on or after January 1, 2009.
- Electronic Medical Record (EMR) progress notes must have the following wording as part of the signature line: "Electronically signed," "Authenticated by," "Signed by," "Validated by," "Approved by," or "Sealed by." The signed EMR record must be closed to all changes.
- Signoff on medical records should be completed in a timely manner.

Diagnosis Documentation Requirements on Progress Note:

- Documentation should include evaluation of each diagnosis on the progress note, not just the listing of chronic conditions, i.e., DM w/neuropathy–meds adjusted, congestive heart failure (CHF), compensated COPD, test ordered, HTN – uncontrolled, hyperlipidemia–stable on meds. CMS considers diagnoses listed on the progress note without an evaluation or assessment as a "problem list," which is not acceptable for risk adjustment submission.
- Use the words "history of" cancer, stroke, etc., to indicate the condition is no longer a current health concern. Avoid using "history of" for conditions the member still has or for which they are being treated. For example, indicating a history of diabetes is not correct. While the member has diabetes in his history, it is still a current condition. Likewise, a patient may have CHF exacerbation in his past, but CHF stable is the current condition. The coding for CHF is the same for both instances — 428.0.
- Each progress note must be able to "stand alone." Do not refer to diagnoses from a preceding progress note, problem list, etc.
- Avoid documentation of diagnosis as probable, suspected, questionable, rule out, or working, rather, document or code to the highest degree certainty known for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.