Blue Medicare Advantage

Provider Bulletin
March 2021

Blue Medicare Advantage working with Optum to collect medical records for risk adjustment

In 2021, Blue Medicare Advantage (BMA) is collaborating with Optum,* which works with Ciox Health* (Ciox), to request medical records with dates of service for the calendar target year 2020 through present day. If you receive a request for medical records, it is because we have received a claim from you for a Medicare Advantage member during the time frame requested. Please make every effort to locate the chart or direct us to where it is housed, even if it is at a different location or combined with records of another provider.

Jaime Marcotte, Medicare Retrospective Risk Program Lead, is managing this project. If you have any questions regarding this program, please contact Jaime at jaime.marcotte@anthem.com or **1-843-666-1970**.

Frequently asked questions (FAQ)

What is Medicare risk adjustment (MRA)?

MRA is the process by which CMS adjusts Medicare Part C (in other words, Medicare Advantage) payments made to Medicare Advantage organizations (MAOs) to account for expected costs of care for their members based on factors associated with each member's demographic characteristics and health status. The MRA payment model is prospective. In other words, diagnosis data collected from one year is used by CMS to predict the costs for the following year. CMS' payment methodology is designed to determine payment to MAOs to enable them to provide comprehensive medical services to Medicare Part C enrollees and not focus on enrolling only healthy members but those that have chronic diseases as well.

The goal of Medicare risk adjustment is two-fold: (i) accurate and complete documentation of diagnosis information by providers to ensure proper treatment, care management, and care coordination services; and (ii) submission of accurate and complete diagnosis data to CMS to help ensure appropriate payment to both the MAO and providers — like you — to support appropriate management of a member's conditions. MAOs like BMA must attest annually, based on best knowledge, information, and belief, that the risk adjustment data it submits to CMS is accurate, complete, and truthful. Accordingly, providers need to maintain accurate and complete medical records supporting diagnosis data submitted to the MAO.

How will I be notified of a request for medical record retrieval?

On behalf of BMA, Optum initiates the record retrieval process through their retrieval partner, Ciox. This process begins with either telephonic or fax outreach to the provider, which is followed by a written request (for example, fax, email, mail, etc.). The written request includes the following:

- Role of the vendor
- Purpose of the medical record retrieval request
- Action being requested (for example, submission of the entire medical record)
- Name of the member
- Date range of service being requested
- Method of submission (for example, provider portal, remote EMR retrieval, onsite chart retrieval, fax or mail, etc.)

* Optum and Ciox Health are independent companies that provide medical record retrieval services on behalf of Blue Medicare Advantage.

Following receipt of such a request, you should supply the medical records within two weeks. If you did not see the member during the requested dates of service, you should return the request to the Ciox with an explanation that no information relative to the request appears on the patient's medical record.

What is the time frame for provider verification process with Ciox?

Depending on the number of charts requested, it can take as little as 10 minutes to verify information, establish a retrieval schedule and send a list of medical charts.

Why did I receive a request for medical records?

If you received a request for medical records, it is because we received a claim for a BMA-covered member during the target year, which includes 2020 dates of service through present day. Retrieval of such information supports submission of complete and accurate diagnosis data for risk adjustment payment. In accordance with the CMS MRA model, CMS evaluates the diagnosis data reported in one year for each Medicare Advantage enrollee coupled with the enrollee's demographic information to estimate the cost of care for such enrollee for the next year. For this reason and others, it is not only important that your patients' current conditions are documented and reported at least once every calendar year, but also that MAOs, like BMA, resubmit assessed and confirmed diagnosis data on a yearly basis.

What criteria must be met for data to be used by CMS for risk adjustment payment?

CMS has strict requirements regarding what data is permitted to be submitted for risk adjustment payment. Diagnosis data submitted for risk adjustment payment must be documented in a medical record based on a face-to-face[1] encounter between a patient and acceptable provider type/physician specialty[2] (*providers*), coded in accordance with standard industry guidelines (in other words, ICD-10-CM), and documented based on dates of service within CMS data collection period as diagnoses do not carry over from one calendar year to the next.

What is the importance of accurate and complete documentation and coding?

It's important to keep in mind that the risk adjustment process also benefits you and your patients.

More complete documentation supports improved coding accuracy, which not only enables a more complete record of all conditions that impact patient care and treatment/management but also helps BMA identify members who may benefit from disease and medical management programs. More accurate health status information can be used to match healthcare needs with the appropriate level of care.

By accurately and completely documenting current, active conditions impacting your patients' health at the time of each encounter, the medical record documentation will illustrate your patients' true health status. Collection of such information by an MAO, such as BMA, via, for example, medical record requests, better equip them to support your patients — our members — in achieving their best health and enable appropriate submission to CMS, yielding more appropriate payment for your patients' care.

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1 In accordance with CMS guidance, face-to-face encounter can be in-person or via telehealth (real-time, interactive audio-video telecommunications system). *April 10, 2020 CMS HPMS Memo; April 29, 2020 CMS Stakeholder Call ; January 15, 2021 CMS HPMS Memo*.

2 Here, providers include only those who are identified by CMS as acceptable physician specialties and provider types, which include Medical Doctors (MDs), Doctors of Osteopathic Medicine (DOs), Physician Assistants (PAs), and Nurse Practitioners (NPs). For full list of acceptable provider types/physician specialties, CMS outlines them **here**

In addition to accurate and complete medical record documentation based on each face-to-face encounter, what must medical record documentation include?

Each medical record must include:

- Patient's first and last name along with the date of service on each page of the medical record.
- All conditions impacting the patient's care/health, including co-existing conditions, capturing patient's true health status.
- Details based on the provider's independent clinical judgment to code to the highest degree of specificity.
- Each condition's impact on patient care, treatment, and/or management.
- Provider's signature, credentials and date.

Medical record documentation should clearly indicate and support all conditions that impact patient care at the time of each encounter. More specifically, providers should document and code current, active conditions that impact patient care, treatment, and/or management accurately and completely to the highest level of specificity. Historical conditions should be only those the patient no longer has and for which the patient is not receiving current treatment. Moreover, conditions considered *resolved* or *historical* in nature should not be documented or coded as current.

What characteristics must medical record documentation have?

Medical record documentation must be clear, concise, consistent, complete and comprehensive. The record must also be legible.

What other requests for medical records may I receive?

In addition to BMA's ongoing medical record retrieval efforts, if CMS conducts an annual risk adjustment data validation (RADV) audit on BMA, you will be required to assist by providing medical record documentation for members identified by CMS for the audit. If this occurs, fax or mail the medical records to:

Attn: Chart Retrieval
Ciox Health
2222 W. Dunlap Ave.
Phoenix, AZ 85021
Fax: **1-972-957-2174**

For more information related to risk adjustment, visit **http://csscoperations.com**.