Medicaid Documentation for Medical Office Staff

Medical office staff know their jobs are fast-paced and they feel as though there is not enough time to meet all of the daily demands. There are phones to answer, calls to make, appointments to set, patients to see, documentation to complete, bills to pay, and insurance claims to file. Regardless of the number of demands, medical professionals and office staff are under strict Medicaid rules governing the submission of claims to Federal programs.

"Each year, in the United States, health care insurers process over 5 billion claims for payment,"[1] and many of those claims are submitted to Medicaid for reimbursement. However, often the claims submitted are improper.[2] According to the Centers for Medicare & Medicaid Services (CMS), in fiscal year 2014, Medicaid improper payments cost approximately $17.5 billion, or 14 percent of all government improper payments.[3] The Government Accountability Office (GAO) says improper payments include those "made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided."[4] CMS is under obligation to protect taxpayer dollars used to reimburse providers for furnishing eligible beneficiaries necessary medical care.[5] Medical providers and office staff also carry this responsibility. "All health care providers have a duty to ensure that the claims submitted to Federal health care programs are true and accurate."[6]

General Medicaid Rules

Medicaid rules vary by State, so it is important to know and understand the rules governing documentation and reimbursement in the States where services are furnished. There are some general rules that apply to all State Medicaid programs. These rules include:

- Beneficiaries are eligible for services at the time they are furnished;
- Services are furnished by licensed, qualified, Medicaid-approved providers;
- Services are medically necessary;
- Medical necessity and medical rationale are documented and justified in the medical record (remember, each State adopts its own medical necessity definition);[7]
- Accurate, clear, and concise medical records are maintained and available for review and audit;
- Physicians' orders or certifications are in the medical record when required (for example, inpatient hospitalizations or home health services);
- All medical record entries are legible, signed, and dated;
- Medical records are never altered;
- Services are correctly coded;
- Only covered services are billed; and
- Overpayments are returned within 60 days.[8]

Documentation Error-Prevention Strategies for Office Staff

Office staff can and should ensure that submitted Medicaid claims meet State and Federal rules by setting and following policies and procedures in compliance with Medicaid rules, performing periodic audits of the medical charts, tracking remittance notice denials, analyzing audit findings along with remittance notices, and taking corrective action to improve outcomes.

- **Policies and Procedures**—Ensure consistency between written policies, standards, procedures, government regulations, and the various compendiums generally relied upon by physicians, other providers, and payers.[9] Ensure policies refer to relevant State standards for medical necessity and State-specific provider laws and regulations. Use the State's administrative code, and if there are further questions, contact the State Medicaid agency to obtain the Medicaid program requirements that apply. Policy also should refer to the Current Procedural Terminology (CPT®) Manual.
- **Periodically Audit**—Providers can use a self-developed tool or borrow a standard audit tool from another organization, such as the generic tools developed by medical associations or insurance companies. View two such examples at http://www.ncmedsoc.org/non_members/project_sustain/Legal/Chart_Audit.pdf and http://www.southshorehospital.org/workfiles/SSPHO//BCBS%20Medical%20Record%20Audit%20Tool.pdf on the Internet. To be more precise with internal audits, developing or borrowing an audit tool that is specific to the practice specialty may be more appropriate. View examples at http://www.omic.com/medical-record-audit-form and https://www.magellanprovider.com/news-publications/handbooks/appendices.aspx on the Internet. Whether providers develop or borrow an audit tool from another organization that fits the specific needs of their practices, the tool should include expected medical record documentation, coding, and billing standards.[10] Choose a staff member who understands documentation, coding, and billing principles to complete the audit. Choose a random sample of records for a specific time period to review. Decide how many records to review, and then pull every "nth" chart for that time period. As part of the audit, track all audit findings. In addition, review and track billing remittance notices.

  Electronic health records (EHRs) require similar methods, but the unique nature of EHRs requires extra precautions.

  1. Make sure auto-fill and keyword features are turned off. Watch for "cloned" notes—notes that appear identical for different visits; these may not reflect the uniqueness of the encounter or the patient's description of their chief complaint.
  2. Make sure all notes have a date and time stamp, even when updating patient history and life events. Separate notes entered at different times by paragraph returns or other clear punctuation or spacing.
  3. Make sure any edits to the patient's record are also initialed or identified with the person making the edit.
- **Analyze Findings**—Analyze audit and remittance notice findings identifying areas for improvement. Determine common problems and trends, such as meeting medical necessity documentation requirements; having physicians' orders in the charts; having claims correctly coded; having legible, signed, and dated records; and returning overpayments within 60 days of identification. Determine documentation, coding, and billing mistakes, the individuals making them, how often the mistakes are occurring, and why mistakes continue to occur.
- **Take Corrective Action**—After identifying the problems and trends, develop operational modifications by developing a corrective action plan to improve outcomes. Corrective action plans typically use a format similar to the following:
  1. Define the problem;
  2. Define the root cause;
  3. Define the actions necessary to correct or prevent the problem;
  4. Define the action to prevent recurrence of the problem or a similar problem;

5. Develop an implementation plan;
6. Educate the staff; and
7. Audit the process again to ensure improved compliance and successful implementation.

There is no point to completing an audit without implementing corrective action and educating the staff.

Fraud, Waste, and Abuse

Most providers and their staff are honest and want to do the right thing. However, some providers and staff are deliberately submitting false claims for reimbursement. Properly filed claims are the responsibility of everyone in the office, and office staff can be at fault if they knowingly participate in fraudulent activities or know of illegal activity and do nothing.[11]

Report Fraud, Waste, and Abuse

If you are aware of or suspect fraud, waste, or abuse, report it to the authorities:

- State Medicaid agency and Medicaid Fraud Control Unit

  https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Report_Fraud_and_Suspected_Fraud.html

- U.S. Department of Health and Human Services, Office of Inspector General

  ATTN: Hotline
  P.O. Box 23489 Washington, D.C. 20026
  Phone: 1-800-447-8477 (1-800-HHS-TIPS)
  TTY: 1-800-377-4950
  Fax: 1-800-223-8164
  Email: HHSTips@oig.hhs.gov
  Website: https://forms.oig.hhs.gov/hotlineoperations

To see the electronic version of this fact sheet and the other products included in the "Documentation Matters" Toolkit, visit the Medicaid Program Integrity Education page at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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