

Medicaid Documentation for Medical Office Staff

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Working in a medical environment can be fast-paced and 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, oftentimes the claims submitted are improper.[2] According to the Centers for Medicare & Medicaid Services (CMS), in fiscal year 2011 Medicaid improper payments cost approximately \$21.9 billion.[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 applying 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 staff;
- 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]

Office Staff Prevention Strategies

Office staff can and should ensure submitted Medicaid claims meet State and Federal rules by setting and following policies and procedures in compliance with the 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 payors.[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 (SMA) 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. Two such examples may be viewed 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> respectively. In order to be more precise with internal audits, developing or borrowing an audit tool that is specific to the practice specialty may be more appropriate. Two examples can be viewed at <http://www.omic.com/medical-record-audit-form/> and https://www.magellanprovider.com/MHS/MGL/about/handbooks/appendices/index.asp?leftmenu=3&sub=child3_2 online. 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 said time period. As part of the audit, track all audit findings. In addition, review and track billing remittance notices.
- 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 similar format 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

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

Fraud, Waste, and Abuse

Most providers and their staff are honest and want to do the right thing. On the other hand, there are those deliberately submitting false claims for reimbursement. Properly filed claims are the responsibility of everyone in the office, and office staff can be culpable 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
<http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Downloads/smafraudcontacts-february2014.pdf>
- 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/>

References

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- 2 U.S. Government Accountability Office. (2011, March 9). Testimony. Medicare and Medicaid Fraud, Waste, and Abuse. Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments. [Highlights]. Retrieved June 27, 2014, from <http://www.gao.gov/assets/130/125646.pdf>
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- 10 U.S. Department of Health and Human Services. Office of Inspector General. (2000, October 5). Notices. OIG Compliance Program for Individual and Small Group Physician Practices. 65 Fed. Reg. 59434, 59437, 59438-39. Retrieved July 1, 2014, from <https://oig.hhs.gov/authorities/docs/physician.pdf>
- 11 False Claims, 31 U.S.C. § 3729(b)(1)(A)(iii). Retrieved July 1, 2014, from <http://www.law.cornell.edu/uscode/text/31/3729>

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