



DIVISION OF MEDICAL SERVICES PROVIDER BULLETIN

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CONDITIONS OF PROVIDER PARTICIPATION REIMBURSEMENT AND PROCEDURE OF GENERAL APPLICABILITY

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SANCTIONS FOR FALSE OR FRAUDULENT CLAIMS FOR TITLE XIX SERVICES.

There have been significant additions and changes to 13 CSR 70-3.030 which were effective November 30, 2005. Reference the complete regulation at <http://sos.mo.gov/adrules/csr/csr.asp>.

ADEQUATE DOCUMENTATION

The Missouri Medicaid program has specific requirements regarding adequate documentation that must be included in the medical record by the provider for the services rendered to a Medicaid patient. The Code of State Regulations, 13 CSR 70-3.030, Section (2)(A) has been **updated** effective November 30, 2005 to define "adequate documentation" more specifically. All providers should take note of this updated regulation as it will serve as a reference for criteria used to determine if documentation supports the code(s) or level of service(s) billed by providers.

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered. An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient/client

specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the following information:

- First name, and last name, and either middle initial or date of birth of the Medicaid recipient;
- An accurate, complete, and legible description of each service(s) provided;
- Name, title, and signature of the Missouri Medicaid enrolled provider delivering the service. Inpatient hospital services must have signed and dated physician or psychologist orders within the patient's medical record for the admission and for services billed to Missouri Medicaid. For patients registered on hospital records as outpatient, the patient's medical record must contain signed and dated physician orders for services billed to Missouri Medicaid. Services provided by an individual under the direction or supervision are not reimbursed by Missouri Medicaid. Services provided by a person not enrolled with Missouri Medicaid are not reimbursed by Missouri Medicaid;
- The name of the referring entity, when applicable;
- The date of service (month/day/year);
- For those Medicaid programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services as specified under 13 CSR 70-91.010 Personal Care Program (4)(A)) the actual begin and end time taken to deliver the service (for example, 4:00 - 4:30 p.m.) must be documented;
- The setting in which the service was rendered;
- The plan of treatment, evaluation(s), test(s), findings, results, and prescription(s) as necessary. Where a hospital acts as an independent laboratory or independent radiology service for persons considered by the hospital as "nonhospital" patients, the hospital must have a written request or requisition slip ordering the tests or procedures;
- The need for the service(s) in relationship to the Medicaid recipient's treatment plan;
- The Medicaid recipient's progress toward the goals stated in the treatment plan (progress notes);
- Long-term care facilities shall be exempt from the seventy-two (72)-hour documentation requirements rules applying to paragraphs (2)(A)9. and (2)(A)10. However, applicable documentation should be contained and available in the entirety of the medical record; and
- For applicable programs it is necessary to have adequate invoices, trip tickets/reports, activity log sheets, employee records (excluding health records), and training records of staff.

A provider's failure to furnish, reveal and retain adequate documentation for services billed to Medicaid can result in the recovery of the payments for those services not adequately documented and can result in sanctions to the provider's participation in the Missouri Medicaid program. This policy continues to be applicable in the event the provider discontinues as an active participating Medicaid enrolled provider as the result of a change of ownership or any other circumstance.

SUPERVISION

The Missouri Medicaid program has specific requirements regarding supervision. The Code of State Regulations, 13 CSR 70-3.030, Section (2)(M) has been updated. Section (3) Program Violations, also addresses this issue. These updates were effective November 30, 2005. Providers should take note of these sections as this will be the basis for criteria used to determine if supervision of services is adequately supported by documentation and whether it is appropriate to be billed by providers.

Supervision means to direct an employee of the provider in the performance of a covered and allowable service such as under the Missouri Medicaid dental and nurse midwife programs or a covered and allowable nonpsychiatric service under the Missouri Medicaid physician program. In order to direct the performance of such service, the provider must be in the office where the service is being provided and must be immediately available to give directions in person to the employee actually rendering the service and the adequately documented service must be cosigned by the enrolled billing provider;

It is a program violation to submit claims for services not personally rendered by the individually enrolled provider, except for the provisions specified in the Missouri Medicaid dental, physician, or nurse midwife programs where such claims may be submitted only if the individually enrolled provider directly supervised the person who actually performed the service and the person was employed by the enrolled provider at the time the service was rendered. All claims for psychiatric, psychological counseling, speech therapy, physical therapy, and occupational therapy services may only be billed by the individually enrolled provider who actually performs the service, as supervision is noncovered for these services. Services performed by a nonenrolled person due to Medicaid sanction, whether or not the person was under supervision of the enrolled provider, is a noncovered service.

Billing for the same service as another provider when the service is performed or attended by more than one (1) enrolled provider is a program violation. Missouri Medicaid will reimburse only one (1) provider for the exact same service.

MEDICAID RECORDS

Providers should note that there have been several changes to the Code of State Regulations, 13 CSR 70-3.030. Please reference <http://sos.mo.gov/adrules/csr/csr.asp> for complete information pertaining to important updates which address adequate documentation, supervision, medical record retention and several other issues. The following information describes updates to section (3) Program Violations:

- Failing to make available, and disclosing to the Medicaid agency or its authorized agents, all records relating to services provided to Medicaid recipients or records relating to Medicaid payments, whether or not the records are commingled with non-Title XIX (Medicaid) records is a program violation.
- All records must be kept a minimum of five (5) years from the date of service unless a more specific provider regulation applies. The minimum five (5)-year retention of records requirement continues to apply in the event of a change of ownership or discontinuing enrollment in Medicaid.

- Services billed to the Medicaid agency that are not adequately documented in the patient's medical records or for which there is no record that services were performed shall be considered a violation of this section.
- Copies of records must be provided upon request of the Medicaid agency or its authorized agents, regardless of the media in which they are kept. Failure to make these records available on a timely basis at the same site at which the services were rendered or at the provider's address of record with the Medicaid agency, or failure to provide copies as requested, or failure to keep and make available adequate records which adequately document the services and payments shall constitute a violation of this section and shall be a reason for sanction. Failure to send records, which have been requested via mail, within the specified time frame shall constitute a violation and shall be a reason for sanction;
- For providers other than long-term care facilities, failing to retain in legible form for at least five (5) years from the date of service, worksheets, financial records, appointment books, appointment calendars (for those providers who schedule patient/client appointments), adequate documentation of the service, and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not is a program violation.
- For long-term care providers, failing to retain in legible form, for at least seven (7) years from the date of service, worksheets, financial records, adequate documentation for the service(s), and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not is a program violation. The documentation must be maintained so as to protect it from damage or loss by fire, water, computer failure, theft, or any other cause.
- Failure to maintain documentation which is to be made contemporaneously to the date of service;
- Failure to maintain records for services provided and all billing done under his/her provider number regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim or both;
- Failure to submit proper diagnosis codes, procedure codes, billing codes regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim;
- Failure to submit and document, as defined in subsection (2)(A) the length of time (begin and end clock time) actually spent providing a service, except for services as specified under 13 CSR 70-91.010(4)(A) Personal Care Program, regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim or both.

A provider's failure to furnish, reveal and retain adequate documentation for services billed to Medicaid can result in the recovery of the payments for those services not adequately documented and can result in sanctions to the provider's participation in the Missouri Medicaid program. This policy continues to be applicable in the event the provider discontinues as an active participating Medicaid enrolled provider as the result of a change of ownership or any other circumstance.

SANCTIONS

Please reference 13 CSR 70-3.030 for a complete listing of Sanctions for false or fraudulent claims for Title XIX Services. Sanctions may be imposed by the Medicaid agency against a provider for any one (1) or more of the following reasons:

- Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable Medicaid program policies or rules, including, but not limited to, the billing or coding of services which results in payments in excess of the fee schedule for the service actually provided or billing or coding of services which results in payments in excess of the provider's charges to the general public for the same services or billing for higher level of service or increased number of units from those actually ordered or performed or both, or altering or falsifying medical records to obtain or verify a greater payment than authorized by a fee schedule or reimbursement plan;
- Breaching of the terms of the Medicaid provider agreement of any current written and published policies and procedures of the Medicaid program (such as are contained in provider manuals or bulletins which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website www.dss.mo.gov/dms, June 15, 2005. This rule does not incorporate any subsequent amendments or additions.) or failing to comply with the terms of the provider certification on the Medicaid claim form;
- Exclusion from the Medicare program or any other federal health care program;
- Failing to correct deficiencies in provider operations within ten (10) days or date specified after receiving written notice of these deficiencies from the single state agency or within the time frame provided from any other agency having licensing or certification authority;
- Being suspended or terminated from participation in another governmental medical program such as Workers' Compensation, Crippled Children's Services, Rehabilitation Services, Title XX Social Service Block Grant or Medicare;
- Billing the Medicaid program more than once for the same service when the billings were not caused by the single state agency or its agents;
- Failing to reverse or credit back to the medical assistance program (Medicaid) within thirty (30) days any pharmacy claims submitted to the agency that represent products or services not received by the recipient; for example, prescriptions that were returned to stock because they were not picked up;
- Billing for services through an agent, which were upgraded from those actually ordered, performed; or billing or coding services, either directly or through an agent, in a manner that services are paid for as separate procedures when, in fact, the services were performed concurrently or sequentially and should have been billed or coded as integral components of a total service as prescribed in Medicaid policy for payment in a total payment less than the aggregate of the improperly separated services; or billing a higher level of service than is documented in the patient/client record; or unbundling procedure codes;

- Failure to comply with the provisions of the Missouri Department of Social Services, Division of Medical Services Title XIX Participation Agreement with the provider relating to health care services;
- Failure to submit and document, as defined in subsection (2)(A) the length of time (begin and end clock time) actually spent providing a service, except for services as specified under 13 CSR 70-91.010(4)(A) Personal Care Program, regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim or both.

Provider Bulletins are available on the DMS Web site at <http://dss.mo.gov/dms/providers/pages/bulletins.htm>. Bulletins will remain on the Published Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletins page.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Web site at <http://dss.mo.gov/dms/global/pages/mednewssubscribe.htm> and subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896