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Guidelines for Record Keeping and Potential Audits

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Overview

- Provider Agreement
- Record Keeping Requirements
- Request for Records Requirements
- Audits and Reviews:
 - Fiscal Audits
 - Potential Outcomes
 - Tips for Successful Audit Outcomes
- Resources



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Disclaimer

The information contained in this presentation was current at the time it was written. It was prepared as a tool to assist providers and is not intended to be all inclusive, grant rights, impose obligations, or function as a stand-alone document. Although every reasonable effort has been made to assure the accuracy of the information within the presentation, the ultimate responsibility for the maintenance of records lies with the provider of services. The State of Alaska – Department of Health and Social Services – and Affiliated Computer Services, Incorporated, employees and staff make no representation, warranty or guarantee that this compilation of information is error-free and/or comprehensive and will bear no responsibility or liability for the results or consequences of the use of this guide.



Provider Agreement

- Providers agree to:
 - Follow procedures that are consistent with guidance in the applicable *Alaska Medical Assistance Provider Billing Manual*.
 - Comply with applicable federal and state Medicaid law.
 - Cooperate in reports, surveys, reviews, or audits conducted by the Department of Health and Social Services (DHSS).



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Provider Agreement

- Providers agree to:
 - Retain records necessary to fully disclose to DHSS the extent of services provided to recipients. Information regarding any payment must be made available, upon request, to DHSS and federal personnel.
 - Allow on-site inspection by authorized representatives of both state and federal agencies connected with the Medicaid program.



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Provider Agreement

- Providers agree to:
 - Be responsible for claims submitted or certified by an authorized representative.
 - Refund to DHSS any reimbursed claim that DHSS finds, does not meet the requirements of 7 AAC 105-160.

Provider Agreement

- Providers agree that:
 - Endorsement of a check received from DHSS certifies that the claim is true and accurate, unless written notice of an error is sent to DHSS within 30 days after the date that the check was negotiated.
 - Providing medical or medically-related services to recipients or billing DHSS for those services constitutes an agreement by the provider that DHSS may take action under 7 AAC 105.260 to recover an overpayment.



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Record Keeping

- Alaska Medical Assistance requires:
 - Provider must maintain accurate financial, clinical, and other records.
 - Records must support the care and services for which payment is requested.
 - A billing service or other entity maintaining records must also meet the requirements.



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Record Keeping Requirements

- Identify the patient information:
 - Recipient receiving treatment
 - Date of service
 - Specific services and extent of each service provided
 - Individual who provided the service



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Record Keeping Requirements

- Financial Record
 - Date of service and charge for each service provided
 - Each payment source pursued
 - Date and amount of all debit and credit billing actions for each date of service
 - Amounts billed and paid



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Record Keeping Requirements

- Clinical Record:
 - Diagnosis and medical need for each service
 - Each service, prescription, supply, or plan of care prescribed by the provider, if applicable
 - Annotated case notes, signed, dated, or initialed by the individual who performed the service, for each service delivered
 - In accordance with applicable professional standards



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Record Keeping Requirements

- Maintain financial, clinical, and other records for at least **seven years** from the date the service is provided.
 - A provider who maintains all or part of the provider's records in an electronic format will ensure that such records are readily accessible.



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Request for Records

- At the request of a DHSS representative or authorized federal or other representative, including an employee of the Department of Law, a provider is required to furnish financial, clinical, and other records that relate to the provision of goods or services on behalf of a recipient:
 - To the person making the request at the address specified in the request
 - No later than the deadline specified in the request
 - Without charge in the form stated in the request



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Request for Records

- Providers may provide copies of the record unless the request specifies the original record must be provided.
- The person making the request may review, copy or take custody of the record.
- Upon request, DHSS may modify or extend the time period for production of the record.



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Request for Records

- If the record is not produced on or before the deadline or the modified or extended deadline:
 - The record may be considered nonexistent.
 - DHSS may deny a payment or may initiate a recoupment, another procedure to recover an overpayment, or sanctions under 7 AAC 105.410, based on a determination of the record's nonexistence.

Types of Audits

- Federal:
 - Department of Health and Human Services:
 - Centers for Medicare and Medicaid Services (CMS):
 - Medicaid Integrity Program (MIP)
 - Payment Error Rate Measurement (PERM)
 - Office of Inspector General (OIG)
 - Department of Justice:
 - Office of the Attorney General
 - U.S. Government Accountability Office (GAO)



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Types of Audits

- State
 - Department of Health and Social Services:
 - Surveillance, Utilization, and Review (SUR)
 - Self audits
 - Quality Assurance and Program Integrity
 - Fiscal audits (7 AAC 160.110)
 - Desk reviews
 - Field audits
 - Department of Law
 - Medicaid Fraud Control Unit (MFCU)
 - Legislative audit



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Why are Audits Necessary?

- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Improper Payments Information Act (IPIA) of 2002 (Public Law 107-300)
- Deficit Reduction Act (DRA) of 2005



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Why are Audits Necessary?

- Claims are paid as a good faith service.
 - Alaska Medical Assistance assumes that the claim received accurately reflects documented services.
- The Medical Management Information System (MMIS) does not stop all claims for review.
- Provider's signature indicates that the claim submitted for payment is accurate.



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Fiscal Audits

- DHSS, or its representative, may conduct a review or audit of a provider to determine compliance with the requirements of 7 AAC 105-7 AAC 160.
- For purposes of conducting a review or audit, the provider will allow representatives of DHSS and its contractors, the federal government and its contractors, or the Department of Law access to original financial, clinical, and other records documenting care provided to Alaska Medical Assistance recipients.



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Fiscal Audits

- DHSS, or its representative, will give a provider 30 days advance notice of a review or audit:
 - Specifying the place where the review or audit is to be conducted.
 - Specifying the records the provider is requested to produce.



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Fiscal Audits

- DHSS, or its representative, will give a provider 30 days advance notice of a review or audit:
 - Specifying the date by which the provider is requested to produce the records and the address to which they are to be delivered or inspected.
 - Advising the provider that the provisions of 7 AAC 105.240 apply to the production of the records requested.



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Fiscal Audits

- Records may be requested and review or audit performed without advance notice when:
 - There is reliable evidence that the provider is in violation of its provider agreement or applicable statute or regulation.
- Providers may request to be advised of the status of a review or audit.
 - DHSS will respond no later than 30 days after receipt of the request.

Fiscal Audits

- If the findings identified in the final audit are determined non-compliant with federal and state regulations and/or the provider billing manual, DHSS will take one or more of the following actions:
 - Recoup or recover an overpayment from the provider
 - Impose sanctions against the provider under 7 AAC 105.410 – 7 AAC 105.420
 - Initiate other civil or administrative actions
 - Refer the matter to another federal, state, or local agency

Fiscal Audits - Right to Appeal

- Right to appeal final audit report:
 - Within 30 days
 - In writing and submitted to the Commissioner's Office
 - Describing the finding or determination being appealed
 - Copy of the finding or determination and basis for appeal
 - Information and material to be considered:
 - Including new information



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Fiscal Audits - Right to Appeal

Commissioner's Office

Department of Health and Social Services

P.O. Box 110601

Juneau, Alaska 99801-0601



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Potential Outcomes

- No findings
- Findings which necessitate:
 - Repayment of funds
 - Attending education sessions
 - Remediation and re-audit
 - Corrective action plans
 - Pre-payment review



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Potential Outcomes

- Findings which necessitate:
 - Referral to licensure/certification entities
 - Suspension or termination from participation
 - Further investigation including civil and/or criminal charges and legal action
 - May lead to criminal conviction, incarceration, financial penalties, etc.



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Types of Errors Found

- Billing for undocumented services or services not rendered
- Including improper entries on cost reports
- Failing to seek payment from primary payment sources
- Assigning incorrect codes or modifiers to secure higher reimbursement

Types of Errors Found

- Characterizing non-covered services or costs in a way that secures reimbursement
- Participating in kickbacks
- No documentation to support the services billed
- Incomplete records:
 - For example, missing identifying information such as patient name and date of birth.

Types of Errors Found

- No documentation of ancillary services
 - Lab and x-ray reports
- Incomplete physician orders
 - Missing date, time, or specific instructions
- No assessment
- No physician orders



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Types of Errors Found

- No signature by provider on progress notes, plan of care, or orders
- No diagnosis
- Surgery consents not signed
- No documentation of any prescription



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Types of Errors Found

- Expired prescription
- No Plan of Care (treatment plan)
- Waiver Plan of Care was not signed by the recipient.
- Personal Care Attendant (PCA) timesheet was not signed by the recipient.



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Types of Errors Found

- Inconsistency in dates noted in various parts of the record.
- Provider did not send any documentation.

Tips

- Document, Document, Document!!!
 - If the service is not documented, it will be assumed to have not occurred and be identified as paid in error.
 - Write everything down.
 - **Make it legible.**
 - Checklists must include applicable handwritten notes.



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Tips

- Document, Document, Document!!!
 - Services coded based on time components must include both start and stop times.
 - Sign and date.



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Tips

- Evaluation and management services
 - Scope of the medical history covered
 - Extent of the physical examination
 - Complexity of your medical decision making
 - Refer to the Common Procedure Terminology (CPT) books
- Legibility of your records
 - Auditors may discount the service
 - Include a list of the abbreviations your practice uses
 - Use standard abbreviations



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Tips

- Assisted Living Homes
 - Paid per day for the care and services, not for residence
 - Document each services provided to the recipient
 - Services such as meals, turning, bathing must be documented in the patient's record.
 - The name of the person rendering the services must be documented.
 - Employee records must be made available.
 - Contact the Division of Senior and Disability Services to obtain an Assisted Living home or Care Coordination packet.



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Tips

- Checklists – No two patients or records are identical
 - Handwritten notes
 - Notes do not have to be full sentences.
- Time-based codes
 - Record must include start and stop times.
 - When multiple time-based services are provided, include start and stop times for each service.
- Sign or initial and date each patient encounter.



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Tips

- CPT Evaluation and Management (E/M) guidelines define how much documentation must be provided for each visit.
- Get the codes right!!!
 - CPT codes MUST match the services rendered.
 - ICD-9 codes MUST be the most descriptive for the patient's diagnosis.
- Financial records must be accurate
 - No credit balances



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Tips

- Demonstrate medical necessity.
 - Ancillary services
 - Note diagnosis and reasons for ordering. Don't assume your reasoning will be clear to an auditor.
- Consider incorporating an internal compliance program.

Tips

- Federal regulations:
 - Code of Federal Regulations (CFR):
 - Title 42 Public Health
 - <http://www.gpoaccess.gov/cfr/index.html>



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Tips

- State legislation and regulations
 - Alaska State Statutes
 - Title 47 Welfare, Social Services and Institutions
http://www.legis.state.ak.us/cgi-bin/folioisa.dll/stattx06/query=*/doc/{t20227}?
 - Title 8 Business and Professions
http://www.legis.state.ak.us/cgi-bin/folioisa.dll/stattx06/query=*/doc/{t1059}?
 - Alaska Administrative Code
 - Title 7 Health & Social Services:
 - 7 AAC 105-7 AAC 160

Resources

- Center for Medicare and Medicaid Services:
 - <http://www.cms.hhs.gov/>
Evaluation and Management Guidelines:
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp



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Preparing for HIPAA 5010

- Centers for Medicare and Medicaid Services (CMS) Standard
- 5010 Implementation January 1, 2012
- Regulate Electronic Transmission of Healthcare Transactions
- 5010 Transactions Testing



Preparing for ICD-10

- Center for Medicare and Medicaid Services (CMS) Mandate
- Two components
 - ICD-10-CM Diagnosis Codes
 - ICD-10-PCS Institutional Procedure Codes
- Service Date Driven
 - Outpatient Claims
 - Inpatient Claims
- Prepare Now



Resources

- CMS ICD-10 Website
- <http://www.cms.gov/ICD10/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
- <http://medicaidalaska.com>



Resources

- CMS 5010 D.0 Websites
 - <http://www.cms.gov/Versions5010andD0/>
 - <http://www.cms.gov/MFFS5010D0/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
 - <http://medicaidalaska.com>

Need Help?

The ACS Website at <http://medicaidalaska.com>

- Provides the necessary information you need for successful billing.
- Includes access to Provider Medicaid Billing Manuals and fee schedules.

Or, you may call:

Provider Inquiry *(907) 644-6800, option 1 or*

(800) 770-5650 (Toll-free in Alaska) option 1, 1

Adult Enhanced Dental Services *(907) 644-9861 Fax,*

(800) 994-7934, or (907) 644-5997

Electronic Commerce Customer Support/PayerPath

(907) 644-6800, option 3 or

(800) 770-5650 (Toll-free in Alaska) option 1, 4

Enrollment *(907) 644-6800, option 2 or*

(800) 770-5650 (Toll-free in Alaska), # 1, 3

Eligibility Verification System *(800) 884-3223 (Toll-free in Alaska)*

Prior Authorization Unit (Travel & MRI only), *option 4 or*

(800) 770-5650, option 1, 2



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