Documentation from a Reviewer Perspective

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WHO

Providers of Services









WHAT

- Tracking
- Informational
- Review
- Common Sense

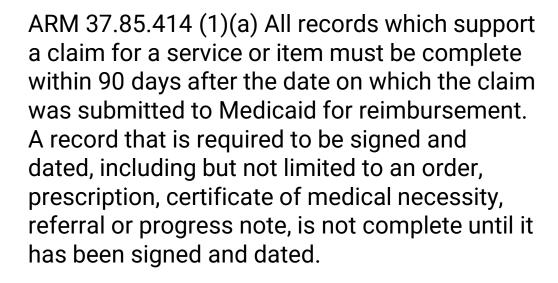


ARM 37.85.414 (1) All providers of service must maintain records which fully demonstrate the extent, nature and medical necessity of services and items provided to Montana Medicaid recipients. The records must support the fee charged or payment sought for the services and items and demonstrate compliance with all applicable requirements.



WHEN

As it happens



Addendums/Corrections

Records cannot be altered and must reflect the services provided. If a record needs to be corrected, a provider should...

- For Written Documentation:
 - Cross out with a single line
 - Write correct information
 - Date and initial the correction
- For Electronic Health Records:
 - Add an addendum to the note/ documentation indicating what's incorrect and what's correct
 - Date and initial the correction



WHERE

- Retention (6 years & 3 months from the date of service)
- Personally Provided Services



ARM 37.85.406 (16) A person enrolled as an individual provider may not submit a claim for services that the provider did not personally provide, inclusive of services provided by another person under the provider's supervision, unless authorization to bill for and receive reimbursement for services the provider did not personally provide is stated in administrative rule or a Montana Medicaid program manual and is in compliance with any supervision requirements in state law or rule governing the provider's professional practice and the practice of assistants and aides.



WHY

If it isn't documented the service cannot be substantiated!





Top Examples of Documentation Errors



Incomplete records:

 An incomplete record can hinder effective patient care and can lead to misunderstandings or mistakes.

 In addition, it does not give a reviewer the full picture of what happened within the service.





Illegible handwriting:

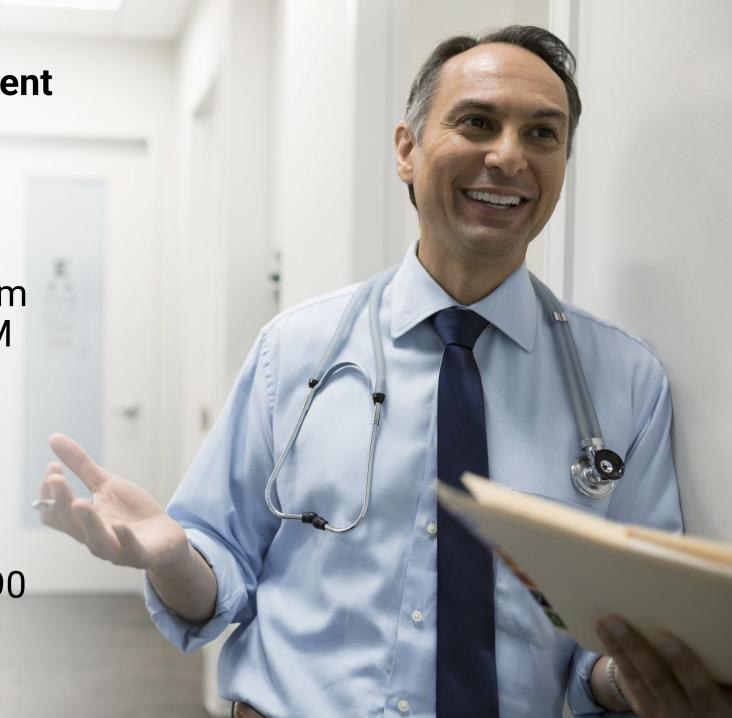
 This can create confusion for other providers who need to access the patient's history and can affect the patient's continuity of care.

 Not to mention making it very difficult for a reviewing party to know what transpired during the service.

Failure to appropriately document corrections:

 Records are required to be signed, dated, and completed within 90 days of billing a claim to Montana Medicaid per ARM 37.85.414.

 If a document must be corrected, the additional information must be signed, dated, and completed within 90 days of the billed service.

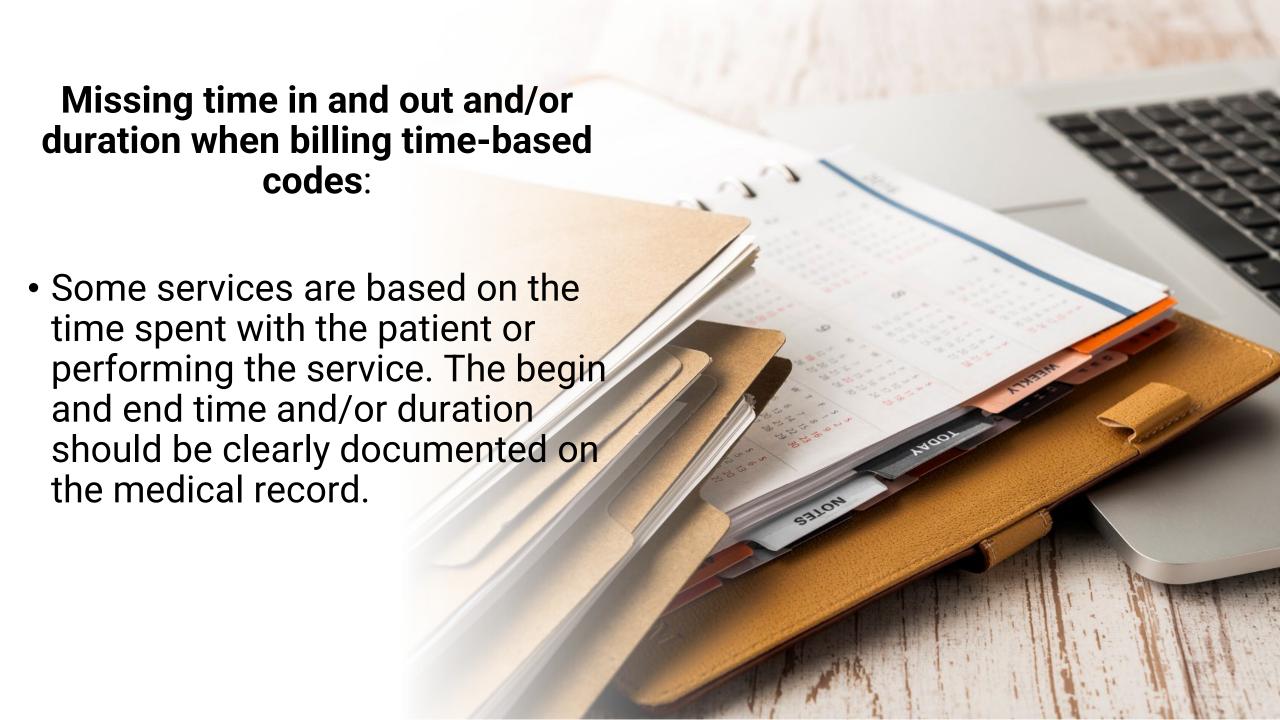




Missing signatures:

 Properly signed documents are essential for legal and billing purposes.

 A record is not complete until it is signed and dated.





Missing patient identifying information on the records:

- In order to verify the documentation is for the billed patient and date of service, the identifying information needs to be listed on each page of the document.
- This includes page count.

Contradicting/Conflicting Information:

 When this type of error is within a document it makes it difficult for a reviewer to verify the correct or accurate information.



Resources



- Documentation for Medical Record Training
 - https://www.youtube.com/watch?v=dgcXVb3LQFM
- Administrative Rules of Montana (ARMs)
 - http://mtrules.org
- General Information for Providers Manual
 - http://medicaidprovider.mt.gov/providertype
- Federal Register
 - Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices pg. 59440
 - https://www.gpo.gov/fdsys/pkg/FR-2000-10-05/pdf/FR-2000-10-05.pdf
- Documentation Matters Toolkit
 - https://www.cms.gov/medicare/medicaid-coordination/states/dcoumentation-matterstoolkit
- HEAT Provider Compliance Training
 - https://oig.hhs.gov/compliance/provider-compliance-training/
- Program Officer





The more information the better!

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