Kansas
Medical Assistance
Program

May 2006 **Provider Bulletin Number 624**

General Providers

General Benefits Provider Manual Update

The Claim/Record Storage Requirements and Documentation Requirements sections in the *General Benefits Provider Manual* have been updated.

K.S.A. 21-3849 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if payment was not received. (This requirement includes primary care case management and lock-in referrals.) This requirement applies to both record availability for manual invoicing and computer generated invoicing.

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, please view the *General Benefits Provider Manual*, pages 2-46 and 2-47.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or 785-274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

2700. DOCUMENTATION REQUIREMENTS
Updated 5/06

Claim/Record Storage Requirements:

~~All providers are required to keep medical, financial, and invoice records for the Kansas Medical Assistance Program for a minimum of five years from the date of service. (This requirement includes primary care case management and Lock In referrals.) This requirement applies to both record availability for manual invoicing and computer generated invoicing.~~

K.S.A. 21-3849 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. (This requirement includes primary care case management and Lock-In referrals.) This requirement applies to both record availability for manual invoicing and computer generated invoicing.

Providers who submit claims via computerized systems (i.e., tape) must maintain these records in a manner which is retrievable as follows:

- A hard copy printout or readable copies from microfilm and microfiche.
- If the required records are retained on machine readable media (i.e., tape), a hard copy of the record must be made available when requested.

If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers (a) to keep such records as necessary to disclose fully the extent of services rendered to beneficiaries, and; (b) to furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider.

Providing medical records to the Kansas Medical Assistance Program or its designee is not a billable charge.

Documentation Requirements:

As with all other insurance carriers, Medicaid has specific requirements regarding documentation of services performed and billed to the Kansas Medical Assistance Program. These requirements are within the standards of each professional scope of practice and are consistent with requirements of other major insurance carriers. The following information regarding documentation requirements is not new, but is provided as education so each provider may ensure all services billed to Medicaid are medically necessary and have been provided as billed.

- The patient record shall be legible and **stand on its own**.
- The date and reason for a service must be included.
- Extent of the patient history and exam must be documented along with a treatment plan.
- Documentation must support the level of service billed.
- Assessments documented merely using a rubber stamp are not accepted unless there is documentation to the side of the stamp which reflects results of the exam for each of the systems identified on the rubber stamp.
- Unless permitted by specific HCBS Program guidelines, **check marks are not accepted**.
- Records must be created **at the time the service is provided**.

2700. Updated 5/06

Progress notes shall include:

- Chief complaints or presenting problems
- Type of history
- Extent of services
- Patient progress and response to treatment
- Evidence of the type of decision made which includes, but is not limited to:
  - Diagnoses
  - Treatment options
  - Extent of data reviewed
  - Risk of morbidity and mortality

The following questions should be asked to ensure appropriate documentation exists to support the level of service billed:

1) Is the reason for the visit documented in the patient record?
2) Are all services that were provided documented?
3) Does the patient record clearly explain why support services, procedures, supplies and medications were or were not provided?
4) Is the assessment of the patient's condition apparent in the record?
5) Does documentation contain information on the patient's progress and results of treatment?
6) Does the patient record include a plan for treatment?
7) Does information in the patient record provide medical rationale for the services and the place of service that are to be billed?
8) Does information in the patient record appropriately reflect the care provided in the case where another health care professional must assume care or perform necessary medical services? Is there documentation of timely referrals?

~~Documentation for the HCBS program must validate services billed were provided in accordance with the plan of care.~~ Recordkeeping responsibilities rest ~~primarily~~ with the provider. When a service is not documented or documentation is not legible, the service is not reimbursed. ~~In the case of a postpayment review, reimbursement will be recouped if documentation is not complete. Please refer to the benefits and limitations section for each waiver specific service regarding documentation and recordkeeping requirements.~~

In the case of a post-payment review, reimbursement is recouped if documentation is not complete or does not meet the general documentation requirements provided in this manual **and the requirements specific to the KMAP program and services provided**. Refer to the provider-specific manual, including its benefits and limitations section and recordkeeping requirements, for additional documentation requirements.

To verify services provided in the course of a post-payment review, documentation in the beneficiary's medical record must support the level of service billed. Documentation for the HCBS program must validate services billed were provided in accordance with the plan of care.

Documentation for any KMAP program created after the fact is not accepted in a post-payment review.