

Missouri Medicaid Audit and Compliance (MMAC)

Provider On-site and Desk Audits

Guidance and Reference Material

I. Commonly Used Terms

Provider: any person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity that enters into a contract or provider agreement with the Department of Social Services for the purpose of providing services to eligible persons and obtaining from the department or its divisions reimbursement for services; 13 CSR 70-3.020(1)(I). Provider also means a person having an effective, valid, and current written provider enrollment application and application for provider direct deposit with the MO HealthNet agency for the purpose of providing services to eligible participants and obtaining reimbursement excluding, for the purposes of this rule (13 CSR 70-3.020) only, all persons receiving reimbursement in their capacity as owners or operators of a licensed nursing home; 13 CSR 70-3.020(1)(I)

Adequate documentation: documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. 13 CSR 70-3.030(2)(A) This is also the definition for adequate records. 13 CSR 70-3.030(2)(A).

Adequate medical records: 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. 13 CSR 70-3.030(2)(A) Adequate medical records are records which are of the type and in a form required of good medical practice. 13 CSR 70-3.030(2) (A).

Adequate and complete patient record: 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:

1. First name, last name, and either middle initial or date of birth of the MO HealthNet participant;
2. An accurate, complete, and legible description of each service(s) provided;
3. Name, title, and signature of the MO HealthNet 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 MO HealthNet. For patients registered on hospital records as outpatient, the patient's medical

record must contain signed and dated physician orders for services billed to MO Health-Net. Services provided by an individual under the direction or supervision are not reimbursed by MO HealthNet. Services provided by a person not enrolled with MO HealthNet are not reimbursed by MO Health-Net;

4. The name of the referring entity, when applicable;
5. The date of service (month/day/year);
6. For those MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services American Medical Association Current Procedural Terminology procedure codes 99291–99292 and targeted case management services administered through the Department of Mental Health and 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;
7. The setting in which the service was rendered;
8. 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;
9. The need for the service(s) in relationship to the MO HealthNet participant’s treatment plan;
10. The MO HealthNet participant’s progress toward the goals stated in the treatment plan (progress notes);
11. 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;
12. 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; and
13. For targeted case management services administered through the Department of Mental Health, documentation shall include:
 - A. First name, last name, and either middle initial or date of birth of the MO HealthNet participant;
 - B. An accurate, complete, and legible case note of each service provided;
 - C. Name of the case manager providing the service;
 - D. Date the service was provided (month/day/year);
 - E. Amount of time in minutes/hour(s) spent completing the activity;
 - F. Setting in which the service was rendered;
 - G. Individual treatment plan or person centered plan with regular updates;
 - H. Progress notes;
 - I. Discharge summaries when applicable; and
 - J. Other relevant documents referenced in the case note such as letters, forms, quarterly reports, and plans of care; 13 CSR 70-3.030(2)(A)

Contemporaneous: at the time the service was performed or within five (5) business days, of the time the service was provided; 13 CSR 70-3.030(2)(D)

Record: any books, papers, journals, charts, treatment histories, medical histories, tests and laboratory results, photographs, X rays, and any other recordings of

data or information made by or caused to be made by a provider relating in any way to services provided to MO HealthNet participants and payments charged or received. MO HealthNet claim for payment information, appointment books, financial ledgers, financial journals, or any other kind of patient charge without corresponding adequate medical records do not constitute adequate documentation; 13 CSR 70-3.030(2)(L)

Claim: bill submitted by a provider to the MO HealthNet Division for MO HealthNet reimbursement for a procedure, a set of procedures, or a service rendered a MO HealthNet participant for a given diagnosis or a set of related diagnoses; 13 CSR 70-3.105(1)(A) Claim or claim for payment also means a document or electronically transmitted data submitted to the Medicaid agency for the purpose of obtaining payment by the Title XIX Medicaid Program. A claim for payment means any one (1) document regardless of how many services, dates of service or recipients to which it pertains. In the case of electronically transmitted claims for payment, a claim for payment means all services for each recipient for which reimbursement is sought in the transmitted information; 13 CSR 70-3.105(1)(A)

Overpayment: an amount of money paid to a provider by the Medicaid agency to which s/he was not entitled by reason of improper billing, error, fraud, abuse, lack of verification, or insufficient medical necessity; 13 CSR 70-3.030(3)(A)

Amount due: an amount of money owed to the Medicaid agency by a provider resulting from a finally determined overpayment; 13 CSR 70-3.030(6)

II. Important Information

All documentation must be made available at the same site at which the service was rendered. 13 CSR 70-3.030(2)(A)

A provider must retain all records for five (5) years. 13 CSR 70-3.030(3)(A) 4. **Also please note:** A provider must make available all records relating to services provided to MO HealthNet participants or records relating to MO HealthNet payments, whether or not the records are commingled with non-Title XIX (Medicaid) records. 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 MO HealthNet. Services billed to the MO HealthNet 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. Copies of records must be provided upon request of the MO HealthNet 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 MO HealthNet 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 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; 13 CSR 70-3.030(3)(A)4

The provider shall advise the single state agency, in writing, on enrollment forms specified by the single state agency, of any changes affecting the provider's enrollment records within ninety (90) days of the change, with the exception of change of ownership or control of any provider which must be reported within thirty (30) days. The Provider Enrollment Unit within the division is responsible for determining whether a current MO HealthNet provider record shall be updated or a new MO HealthNet provider record is created. A new MO HealthNet provider record is not created for any changes, including, but not limited to, change of ownership, change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/ offices that have been closed and reopened at the same or different locations. This includes replacement facilities, whether they are at the same location or a different location, and whether the Medicare number is retained or if a new Medicare number is issued. If a new provider record is created in error due to change information being withheld at the time of application, the new MO HealthNet provider record shall be made inactive, the existing provider record will be made active, the existing provider record shall be updated, and the provider may be subject to sanction. The division shall issue payments to the entity identified in the current MO HealthNet provider enrollment application. Regardless of changes in control or ownership, the division shall recover from the entity identified in the current MO HealthNet provider enrollment application liabilities, sanctions, and penalties pertaining to the MO HealthNet program, regardless of when the services were rendered.

III. AUDIT PROCEDURES

MMAC auditors may conduct a "desk audit," meaning they will request that you send records by mail, fax, or email, without coming on-site. If this happens, you will receive a request for records. The auditor will review the records when they are received. If any records are missing, it is usually appropriate for the auditor to contact you to let you know. Be sure the auditor has good contact information for you.

MMAC auditors may conduct an on-site visit. If they do, they will usually call you at least one day prior to their arrival. They will generally be able to let you know their estimated arrival time and the time period being reviewed (dates of service for the audit.) The auditors will ask you for a contact person, and they will do their best to let you know how many MMAC auditors will be on-site (our auditors usually travel in pairs). They will talk to you about where they can set up their scanners and laptops, and they will generally

provide you with a partial list of participants' names so some records can be pulled in advance, to minimize time on-site.

Once on-site, the auditors will give you the complete list of participant names included in the audit, and a list of the documents they are requesting. They will provide you with a notification letter for your records. Auditors will ask you if you have a copy of, or access to, the MO HealthNet provider manuals and bulletins. These are available via the internet at these locations: <http://manuals.momed.com/manuals/> and <https://dss.mo.gov/mhd/providers/pages/bulletins.htm>. If you need assistance locating these or signing up for updates, the auditors will assist you. Auditors will then scan the requested documentation.

To sign up for email blasts posted by MO HealthNet, please follow the link below and provide an appropriate email address: <https://dss.mo.gov/mhd/>

Auditors should generally ask you if they notice missing documentation or if it appears you might refer to a document by a different name. Auditors may ask questions of your personnel, ask to tour the site, and may ask to look at equipment or medication areas.

Before leaving the audit site, auditors will complete a Billing Checklist with you. This helps the auditor understand your billing procedures. The auditors will complete a Documentation Disclosure Statement with you. Any missing documentation that the auditors are aware of, will be noted on the form. The auditors will hold an exit conference with you if you like.

After returning to the office, the lead auditor will complete the audit. The completed audit may indicate there are no findings or violations noted. You will receive a "no findings" letter. If there are violations noted, the auditor will compile those as an attachment for you, and you will receive notice of the completed audit and the noted violations. The auditor will determine the appropriate sanction by following the guidelines in state regulation 13 CSR 70-3.030. The appropriate sanction could include education, or recoupment of improperly paid claims ("overpayment"). The attachment you receive will clearly indicate the sanction for each error.

Some audits result in MMAC's Investigations Unit opening an investigative case. This could be due to complaints or referrals received on the provider, suspicious or concerning audit findings, or other factors. Generally, if a completed audit becomes part of an investigation, you will not receive your "no-findings" or "findings" letter as quickly. If you feel it has been a long time since your audit, and you have not heard from MMAC about the results, you should feel free to contact us.

If your audit results include recoupment for errors found, you will receive notice about how to make repayment arrangements, and how to appeal the decision, in your letter. As well, MMAC contact information is included in the letter in case you have any questions.

MMAC may use statistical sampling of claims for payment when conducting an audit. MMAC follows the rules set forth in 13 CSR 65-3.060, "Computation of Provider Overpayment by Statistical Sampling" (Effective update on 04/30/19). Some important definitions regarding the methods of selecting claims for statistical sampling include:

- (1) A Disproportionate Stratified Random Sampling;
- (2) A one hundred percent (100%) review of all claims within a review group; or
- (3) a random claim-by-claim selection within a review group.

The following are definitions relating to statistical sampling:

Disproportionate Stratified Random Sampling Technique: means a sampling method in which the size of the sample drawn from a particular stratum is not proportional to the relative size of that stratum.

Sampling Unit: means one (1) of the units into which an aggregate (e.g. total paid on claims) is divided for the purpose of sampling. For example a sampling unit may be ICNs, a specific procedure code or codes, or participant DCNs (Document Control Numbers);

Stratum: refers to a sampling method in which the universe is divided into non-overlapping subgroups. Each of the subgroups is called a stratum, and two (2) or more subgroups are called strata.

Universe: means all claims for payment or all claims relating to a specific service or a specific item or merchandise submitted by a provider between two (2) certain dates.