

Provider Training Series

Chapter 45, Sections 7 and 8

Provider Recordkeeping, Data Collection, and Documentation Standards (Module #10)

Wyoming Department of Health
Division of Healthcare Financing
DD Waiver Provider Training Series



Welcome to the Division of Healthcare Financing (Division), Home and Community Based Services Section's Provider Training Series for Chapter 45 of the Department of Health's Medicaid Rules (Rules). These rules govern the home and community based Comprehensive and Supports Waivers, hereinafter referred to as the DD Waivers.

Chapter 45, Section 15(d) states that all people who are qualified to provide waiver services shall complete training in specific areas prior to delivering services. Although some provider organizations may choose to develop their own training modules, individuals who complete all of the Series training modules and associated training summaries will be in compliance with this specific requirement. Please note that there are provider training requirements established throughout Chapter 45, and it is the responsibility of providers to ensure they meet **all** training requirements prior to delivering waiver services.

This module covers Sections 7 and 8, which address provider recordkeeping systems, data collection, and documentation standards.

Purpose of This Training



To clearly outline provider responsibilities related to generating and maintaining service and billing documentation, keeping financial and program records, and collecting and analyzing data.

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Training Agenda

- ▶ Maintaining a systematic recordkeeping system
- ▶ Sharing records and information
- ▶ Paper and electronic documentation standards
- ▶ Service and billing requirements
- ▶ Availability of documentation

By the end of the module addressing provider recordkeeping, data collection, and documentation standards, the following topics will have been introduced and explained.

- The importance of maintaining a systematic recordkeeping system, and the specific requirements for the system.
- The standards that must be met in order for the provider to share information and records, and when the sharing of information and records is required.
- The specific standards that apply to paper and electronic billing and service documentation.
- The requirements that apply to documenting and billing for services that are delivered.
- And finally, the provider's obligation to make service and billing documentation available to the case manager.

Please note that, for the purpose of these trainings, providers include provider staff and case managers, unless there is a specific need to make a distinction.

Choice



Freedom to make choices is a human right. It is the responsibility of all providers to offer and respect participant choice. Documentation should reflect that choice has been offered and respected.

A theme throughout all of the Division's provider training modules is the fact that home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives. It is the responsibility of all DD Waiver providers to offer and respect participant choice. Documentation in the individualized plan of care (IPC), provider service documentation, incident reports, positive behavior support plans, and other reports and documentation formats should demonstrate how participants were offered choices, and how those choices were respected. This documentation ensures provider accountability, and reflects the work that providers are doing.

Systematic Recordkeeping Systems



Section 7 establishes the rules related to provider recordkeeping systems

Section 7 - Provider Recordkeeping and Data Collection - establishes the rules related to provider recordkeeping systems.

What Must the System Include?

- ▶ Providers must collect and maintain data, records, and information that is necessary to provide services.
- ▶ Providers must ensure permanency, accuracy, completeness, and easy retrieval of information.
- ▶ Entries must be dated, legible, and identify the documenter.
- ▶ Recordkeeping system must include a separate record for each participant.

Providers are required to collect and maintain data, records and information that is necessary to provide services. They must have a system that ensures the information they maintain is accurate, complete, permanent, and easy to retrieve in the event that it is needed for any reason. All entries must be dated, and must be legible. Additionally, documentation must identify the person who provided the service and created the documentation. This identification is important so that providers accurately reflect the services provided, case managers clearly understand who provided the services, and the Division and other entities such as Protection and Advocacy, the Medicaid Fraud Control Unit (MFCU), or the Centers for Medicare and Medicaid Services (CMS) are able to hold providers and provider's staff members accountable for the services they provide and the documentation they generate. Later in this training we will discuss some of the billing limitations related to providers billing for more than one service. This identification will help the provider demonstrate that they are in compliance with Medicaid Rules.

Participant records must be documented and maintained separately. If three participants are involved in the same activity, the activity must be documented for each participant on separate schedules, and maintained in separate files.

Retention, Storage, and Destruction

The provider shall develop a process relating to retention, safe storage, and safe destruction of the participant's records to ensure retention of necessary information and to protect confidentiality of records. The provider shall retain all records relating to the participant and the provision of services in accordance with Chapter 3 of the Department of Health's Medicaid Rules.

As established in Section 7, once the documentation is generated, the provider is responsible for ensuring it is retained, stored, and destroyed in accordance with Chapter 3 of the Department of Health's Medicaid Rules. Confidentiality must be maintained at all times.

Chapter 3 - Provider Participation



To review Medicaid Rules, visit <https://rules.wyo.gov/>.

1. Select *Current Rules*
2. Select *Health, Department of (048)*
3. Select *Medicaid (0037)*
4. Select the Chapter you wish to review

Chapter 3, which addresses provider participation, outlines specific requirements that relate to the safe retention, storage, and destruction of records for all Medicaid providers. DD Waiver providers should be familiar with these requirements. To read or download these rules, follow the instructions that are listed on the slide.

Sharing Records and Information



Providers must follow standards outlined in the federal Health Insurance Portability and Accountability Act (HIPAA) when sharing private and identifiable health information related to the participants they serve.

Providers will, at times, be required to share information with case managers, other providers, medical professionals, and state and federal agencies. It is imperative that providers follow standards outlined in the federal Health Insurance Portability and Accountability Act (HIPAA) when sharing private and identifiable health information related to the participants they serve.

Release of Information

- ▶ Providers must have policies that govern access to, duplication, dissemination, and release of information.
- ▶ Providers must obtain written authorization before they release participant information that can identify or be associated with the participant.

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Providers must establish and implement policies that clearly outline how participants, staff members, and others have access to participant records, and how and when those records will be duplicated or disseminated. The policy must also establish requirements related to releases of information. Providers are required to obtain written authorization from the participant or legally authorized representative before they can release information that can identify or be associated with the participant.

Releasing Records to State and Federal Authorities

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Providers shall make all records maintained or controlled by the provider available upon request to Division staff, representatives from the State or Federal Medicaid programs, or the Medicaid Fraud Control Unit, without prior written authorization, consent, or other form of release.

The Division of Healthcare Financing, state and federal Medicaid programs, and the MFCU are entitled to access provider records at any time without prior written authorization, consent, or release. Providers must make records available to these entities upon request.

Changes in Ownership

- ▶ Complete and accurate copies of participant records shall be transferred to the participant's new provider.
- ▶ Provider shall follow Medicaid disenrollment procedures prior to dissolving a provider agency.
- ▶ Division must be notified in writing of the location and secure storage of remaining participant records.

Over the years, providers have closed their businesses, stopped providing services, or sold their business to another entity. Even though a provider may no longer offer services, they are still responsible for the records they created during their tenure as a DD Waiver provider.

If a provider entity is changing ownership, the provider must ensure that complete and accurate copies of participant records are transferred to the participant's new provider.

Providers are not just DD Waiver providers...they are Medicaid enrolled providers, and must follow the disenrollment procedures established by Medicaid before they dissolve a provider agency.

Chapter 3 establishes the length of time that providers are required to retain records. This requirement is still in place if the provider chooses to disenroll as a Medicaid provider. The provider must notify the Division in writing of how the secure storage of participant records will be maintained, and the location of that storage.

Documentation Standards



Section 8 establishes the documentation standards for providers of all DD Waiver services. These standards are in addition to those outlined in Chapter 3.

Section 8 establishes the documentation standards for providers of all DD Waiver services. Again, these standards are in addition to the standards outlined in Chapter 3. All providers are required to verify that they have read and understand the documentation standards, and ensure that they meet the standards for the documentation they use to substantiate their billing. The document used to verify these standards can be found on the [HCBS Document Library](#) page of the Division website, under the *DD Certification Forms* tab.

The purpose of documentation is to support the claim that will ultimately be submitted to pay the provider for the service. Although documentation should include information on what the participant did, it is equally important for the documentation to clearly outline what the provider did to support the participant.

Written Documentation - Each Physical Page

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- ▶ Full legal name of the participant;
- ▶ IPC start date;
- ▶ Service name and billing code;
- ▶ Legible signature of each person performing the service, if initials are being used for documentation.

Providers may use paper or electronic systems to document participant services. The following information must be included on every physical page of paper documentation:

- The full legal name of the participant. If the participant's name is Jennifer, but likes to be called Jenny, then the provider should use Jenny when documenting. However, there should be a header or footer that includes Jenny's full legal name on every page.
- The start date of the IPC.
- The name of the service that is being documented, and the billing code of the service. If you are providing Basic Adult Day Services for Jenny, the header or footer of each page should indicate that the documentation is for Jennifer Lynn Jones, Adult Day Services - Basic, with a billing code of S5100.
- Finally, a legible signature of each person performing the service should be included on every page if initials are being used to identify the provider or staff member who is creating the documentation.

The Division has examples of participant schedules that providers can download and edit to meet their particular needs. These examples can be found on the [HCBS Document Library](#) page of the Division website, under the *DD Examples/Templates* tab.

ALL Documentation - Each Time a Service is Documented

- ▶ Location of services;
- ▶ Date of the service, including year, month, and day;
- ▶ Time services begin and end;
- ▶ An initial or signature of the person performing the service; and
- ▶ Detailed description of the services provided.

Each time a service is documented, the provider must include the following information:

- Where the service occurred, such as the participant's home, Walmart, or the park. The physical location needs to be readily identifiable. Using building nicknames, such as Main Street home, is not acceptable.
- The date of the service, including year, month, and day. When documenting community living services, which typically spans more than one day when delivered overnight, documentation should end at 11:59PM on one day, and begin at 12:00AM on the next.
- The time services begin and end. Providers must use either AM and PM, or use military time. Simply documenting 3:00 is not sufficient.
- An initial or signature of the person performing the service. As a reminder, if the provider uses initials to document, then the signature must be at the bottom of every page of documentation on which an initial is present.
- Most importantly, documentation must include a detailed description of the services provided.

What Does “Detailed Description” Mean?

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- ▶ Personalized list of tasks or activities that describe a typical day, week, or month in the life of the participant;
- ▶ Supports recommendations from assessments by medical and behavioral professionals;
- ▶ Reflects the participant’s desires and goals; and
- ▶ Includes specific objectives, support needs, and safety needs.

So, what is expected from a detailed description of services? Simply stated, documentation must provide an explanation of what the participant did, **and** the service that the provider delivered. The description must also support the service definition that is established in the Comprehensive and Supports Waiver Service Index (Service Index). The service the provider delivers should support recommendations from medical and behavioral professionals, and the documentation of the service should reflect that support.

Documentation should occur on an individualized schedule that includes personalized tasks or activities in which the participant regularly participates, and should reflect what the person wants to do and the goals they wish to achieve, and specific support and safety needs that should be addressed during the delivery of services. If the service is a habilitative service, their specific objectives should be included on the schedule as well.

Detailed Documentation - An Example

Jenny went to Taco Bell. Before going into the restaurant, we discussed how much money she had to spend, and the importance of ordering iced tea or a diet soda rather than regular soda since she has diabetes. When she went to order, she had difficulty seeing the menu, so I prompted her to ask for a written menu so she could make her decision without pressure. She chose to order a regular soda, but we again discussed her diabetes and she agreed that ordering the smallest size would be the best choice for her health. When paying, she inserted her debit card backward. I prompted her to insert her debit card with the chip side first, and showed her the picture on the card to help her remember in the future.

Remember, it is important that documentation reflect what the participant did, but it is equally important that the documentation clearly outlines what the provider did to support the participant. In this example, the documentor explains that Jenny went to Taco Bell for dinner, but then provides detail on what they did to support Jenny during this time.

Read slide.

Electronic Documentation



- ▶ All data required for written documentation;
- ▶ Electronic signatures and automatic date stamps; and
- ▶ Automated tracking of all attempts to alter or delete information.

Providers that use electronic documentation must meet additional standards. In addition to most of the standards established for written documentation, they must also capture electronic signatures and automatic date stamps, and be able to track each attempt to alter or delete information. Please keep in mind that it is the provider's responsibility to make sure that they are keeping records appropriately. If a provider has questions about the electronic system they want to use, they can contact a Provider Credentialing Specialist at wdh-hcbs-credentialing@wyo.gov. If a provider uses a system that doesn't meet the requirements outlined in this Section, they may be subject to a recovery of funds for the payment that was tied to that documentation.

Electronic documentation does not require a signature at the bottom of each page if an electronic signature of the person who enters the data is being captured.

Altering or Deleting Electronic Documentation

- ▶ Electronic records shall not be altered or deleted unless incorrect, and the purpose of the alteration is documented.
- ▶ If someone other than the employee who provided the services completes the electronic documentation, the provider must maintain all written documentation to support the claim.

Although a mechanism for tracking altered or deleted information is required, this does not mean that electronic records should be altered or deleted as a rule. Documentation should only be altered or deleted if it is incorrect, and the reason for the alteration or deletion must be explained as well.

If an individual other than the provider or staff member who delivered the service, such as a clerical staff member, enters the electronic documentation, the provider is required to maintain the original written documentation to support any claim that is submitted for payment.

Case Manager Access to Electronic Documentation

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A provider shall make a participant's electronic case file, specific to the case manager's caseload, available to the case manager in the electronic record in order to comply with the required documentation reviews and service unit utilization specified in this Chapter.

Providers must make each participant's electronic record available to the participant's case manager so the case manager can complete their required documentation and billing reviews. Please remember, while a provider may work with a specific electronic platform, the case manager may have to work with several, depending on who is on their caseload. It is expected that providers conduct training with the case managers so they can retrieve the information they need. Simply providing a username and password is not sufficient. Providers must clearly outline the steps that are necessary for the case manager to retrieve the information, and provide additional training if the case manager requests it.

Case Manager Electronic Documentation

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- ▶ Documentation in EMWS meets the requirements for electronic documentation.
- ▶ Records in EMWS shall not be altered once the case manager bills for the service provided.

Discussion Topics	
<p>Community Integration</p> <p>What did you do in the community this month?</p> <p>Are you satisfied with the activities you did this month?</p> <p>What activities do you hope to do next month?</p> <p>Notes</p>	<p>Lecture</p> <p>Church/Cultural Events</p> <p>Errands</p> <p>Other</p> <p>Unknown</p>
<p>Delivery of Services</p> <p>Where do you receive most of your services?</p> <p>Are you receiving services in the community as much as you want to?</p> <p>Notes</p>	<p>Unknown</p>
<p>Health/Medical</p> <p>Have there been changes in the participant's health? Any new medication changes or medical needs? Also ask about PRN medication usage, if applicable.</p> <p>Notes</p>	<p>Unknown</p>
<p>Provider Satisfaction & Concerns</p> <p>Are you being treated with respect?</p> <p>Do you have any concerns or issues with your providers? What would you like them to do differently for you if you have concerns?</p> <p>Notes</p>	<p>Unknown</p> <p>Unknown</p>
<p>Friendship/Social Interactions</p> <p>Are you getting to spend time with your friends if you want to?</p> <p>Do you need help connecting with your friends to spend time with them?</p> <p>Notes</p>	<p>Unknown</p> <p>Unknown</p>
<p>School Attendance & Satisfaction</p> <p>Are there any barriers to a successful education for you?</p> <p>Notes</p>	<p>Unknown</p>

Case managers are required to submit their documentation through the Electronic Medicaid Waiver System (EMWS). This system meets the requirements for electronic documentation. Once a case manager submits a claim for payment, they cannot alter their documentation in EMWS. Although case managers are encouraged to complete the Case Manager Monthly Review Form as soon as they provide a service, the form cannot be *submitted* in EMWS prior to the last day of the month if the case manager is delivering a monthly case management unit.

Service and Billing Requirements



Section 8 establishes specific requirements and limitations related to documentation and billing for services.

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Additional Documentation Requirements

- ▶ Different services must be documented on separate forms.
- ▶ Documentation must be legible, retrieved easily, complete, and unaltered.
- ▶ Written documentation must be completed in permanent ink.

We've already stated that each participant must have services documented separately. Additionally, each service that a participant receives must be documented separately. So, if Jenny and Sally both receive Adult Day Services, then there would be two individual schedules for Adult Day Services...one for Jenny and one for Sally. If Jenny receives Adult Day Services and Community Living Services, then there would again be two individual schedules for Jenny...one for Adult Day Services and one for Community Living Services.

Documentation must be legible. It doesn't do any good to write something down if no one can read what it says. Remember, documentation is justification for payments made with public monies, and is subject to review and scrutiny by state and federal authorities. Please make sure that documentation is professional. It must also be easily retrieved for the case manager's review, and in the event that it is requested a state or federal authority. It must be complete and unaltered.

If a provider uses a paper system to document, all documentation must be completed in permanent ink.

Additional Documentation Requirements (Continued)

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- ▶ Services must be provided in accordance with the Comprehensive and Supports Waiver Service Index and the participant's IPC.
- ▶ Participants must be in attendance for direct waiver services.

When completing documentation, it is important that providers reflect how the provided service aligns with the service definition outlined in the Service Index and the participant's IPC. If the provider is delivering a direct waiver service, they must ensure that the participant is in attendance. A provider cannot provide Companion Services, as an example, if the participant isn't there.

The only services that are not direct services are Environmental Modifications, Homemaker Services, and Specialized Equipment. Limited Case Management and Supported Employment Services can be delivered as a non-direct service as well.

Service and Billing Limitations

- ▶ Providers must complete all documentation at the time that the provider submits the claim.
 - ▶ Documentation completed or altered after the submission of a claim is prohibited.
- ▶ Providers shall not bill for more than one direct service for the same participant.
- ▶ Provider staff members shall not bill for more than one direct service for different participants at the same time.

Providers must ensure that their documentation is complete and accurate before they submit a claim for payment. Once a claim is submitted, they cannot alter the documentation. Documentation that is altered after the claim is submitted may be considered fraudulent, and will be subject to recovery.

A provider cannot bill for more than one direct service for a participant at the same time. If Jenny has both Adult Day and Community Living Services, the provider cannot bill for both of those services during the same time frame.

A provider staff member cannot bill for different services for different participants at the same time. As an example, Polly Provider works with Jenny and Sally. Jenny receives Adult Day Services during the day, and Sally receives Companion Services. Polly would not be able to bill for both Jenny and Sally during the same time frame since they are receiving different services.

Availability of Documentation



Providers must ensure that service and billing documentation is available to the case manager within the timelines established in Section 8.

Case managers are required to review provider service and billing documentation for each participant on their caseload. Providers must ensure that this documentation is available to the case manager within the timelines established in Section 8.

Providers Must Make Documentation Available to Case Managers

- ▶ Service documentation - 10th business day of the month following the date the services were provided.
 - ▶ If services were not provided during the month, this information must still be submitted to the case manager.
- ▶ Billing information - 10th business day of the month after billing has been submitted for payment.

Providers must ensure that service documentation is available to case managers by the 10th business day of the month following the date the services were provided. If services were provided on March 31st, then the documentation must be available to the case manager by the 10th business day in April. If a provider didn't deliver services during March, they must notify the case manager of that fact in writing. If this information isn't submitted to the case manager by the 10th business day of the following month, the provider will be in violation of this rule.

Medicaid providers have up to one year to bill for the services they provide. So, while they must make service documentation available by the 10th business day of the following month, billing documentation must be made available by the 10th business day of the month after the bill has been submitted. For example, Polly Provider provided services to Jenny in October 2020. She did not submit a bill to get paid for those services until March 10, 2021. Polly must make her service documentation available to the case manager by the 10th business day of November 2020. She will need to make her billing documentation for those services available to the case manager by the 10th business day of April 2021.

Failure to Make Documentation Available...

- ▶ ...may result in corrective action or adverse action.
- ▶ The case manager must notify the provider and Division of the rule violation.



If a provider fails to make documentation available to the case manager as established in Section 8, the case manager is required to notify the Division of the rule violation by completing the Provider Documentation Non-Compliance Report, which can be found on the [HCBS Document Library](#) page of the Division website, under the *Forms* tab. Even if a provider makes the information available to the case manager after the 10th business day, it is still a rule violation and the case manager is obligated to notify the Division. Providers that violate this rule may be subject to corrective action.

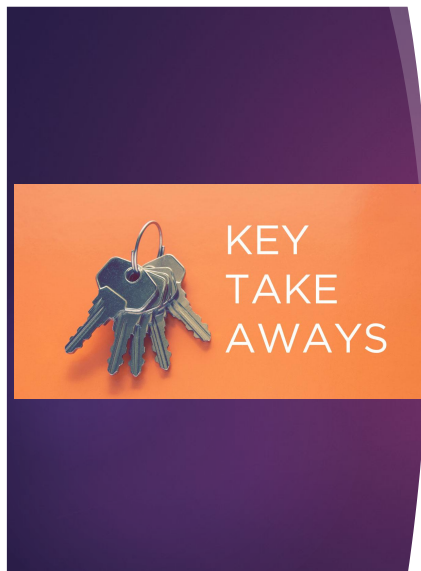
If there are repeated instances of provider non-compliance, the case manager is obligated to file a complaint through the Division's complaint process.

Case Managers Have Documentation Requirements Too!

- ▶ Monthly and quarterly reports must be documented in EMWS.
- ▶ Monthly case manager reviews must be completed prior to billing for services.
- ▶ Monthly case manager reviews must be submitted within sixty (60) calendar days of the service being provided.

Case managers are responsible for notifying the Division if a provider violates rules. However, case managers have documentation requirements that they must meet as well. They must document their services for each participant on the monthly and quarterly reports that are found in EMWS. Case managers must complete and submit monthly documentation within sixty calendar days of providing the service. Although case managers have up to sixty calendar days to complete documentation, best practice suggests that documentation of services should occur as soon after the service is delivered as possible. This will ensure the case manager's best recollection of what occurred, allow for a more detailed description of events, and keep the participant's record as up-to-date as possible.

As a reminder, case managers must submit their documentation before they bill for the service.



1. Providers must adhere to all documentation standards set forth in Sections 7 and 8.
2. Providers must have a systematic recordkeeping system and adhere to requirements for safe record storage and destruction.
3. Providers must meet established timeframes for submitting documentation and making it available to appropriate parties.

As we end this training, we'd like to review some of the key takeaways:

1. Providers must adhere to all standards for written and electronic documentation set forth in Sections 7 and 8. These standards include requirements related to completeness and legibility of documentation.
2. Providers must have a systematic recordkeeping system and adhere to requirements for safe record storage and destruction. Providers should refer to Chapter 3 of the Department of Health's Medicaid Rules for specific information on the documentation requirements for Medicaid providers.
3. Providers, including case managers, must meet established timeframes for submitting documentation and making it available to appropriate parties.

Questions???

Contact your Provider or Benefits and Eligibility Specialist

<https://health.wyo.gov/healthcarefin/hcbs/contacts-and-important-links/>

Thank you for participating in the training on provider recordkeeping, data collection, and documentation standards. If you have questions related to the information in this training, please contact your Division representative. Contact information can be found by clicking on the link provided in the slide.

Don't read this section as part of the live presentation

Please be sure to complete a summary of this training so that you can demonstrate that you received training on the rights of participants receiving services.