

**Comments and Responses on ARC 8084B**  
Amendment of Medicaid Documentation Requirements for Certain Services  
Received September 15, 2009

The following persons and organizations provided written comments, which are included in the summary below:

Kim Smith Crittendon Center  
Lynne Reed, IME Surveillance and Utilization Review Unit, Des Moines

**Effect**

COMMENT: This proposal opens up to the possibility of more fraudulent activity for providers. By not documenting the actual time spent with the patient, as a unit that does postpayment reviews we are unable to determine duplicate billing patterns, which is a problem we have identified within different waiver programs, during therapy sessions, etc.

This can also lead to upcoding for services, and does not lend a way for a provider to substantiate their charges. As they are not able to substantiate at what point they are with what patient or at what point a different funding source takes over. (Reed)

RESPONSE: CPT codes are used by traditional Medicaid providers to bill for services. Non-traditional providers, such as Medicaid waiver providers, bill by the unit based on time; they do not bill CPT codes. Recording beginning and ending times does not apply to documentation used to bill a CPT code, even if the CPT code has a time-related definition.

**Time Recording**

COMMENT: Which do you recommend we record in the patient chart 1:00 pm to 1:20 pm or 20 minutes or both. Also is this still just the face to face time with the patient (or patient family) or does this include the documentation time also? (Smith)

RESPONSE: The Department recommends using time periods (e.g., 1:00 pm to 1:20 pm) for recording time for CPT codes. Regarding billing for direct (face-to-face time) and indirect (documentation time), document in the manner that is required for that specific CPT code.