



INFORMATIONAL MEMO

Title: Accurate Nursing Documentation and Compliance with Regulatory Requirements	Topic: Home Care
Audience: Home Health Agencies, Registered Nurses, Licensed Practical Nurse	Sub-Topic: Provider Guidance
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Legal Authority: 10 CCR 2505-10, Section 8.520 and 8.540; 42 CFR § 484.110; CRS 12-255-119(3)(b)(I) and §12-255-101 et seq.; 3 CCR 716-1, Chapter 1	
Memo Author: Christine Merriman	
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Purpose:

This memo serves as a reminder to all home health providers and nursing staff regarding the critical importance of accurate documentation in accordance with Colorado Board of Nursing regulations and Colorado Department of Health Care Policy and Financing (HCPF) standards. Accurate, timely, and complete documentation is essential for ensuring high-quality patient care, legal and regulatory compliance, and program integrity, regardless of the setting in which the care is provided.

Nursing Documentation Responsibilities

Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) practicing in home health settings are required to:

- Document all care provided in a manner that is complete, timely, and reflective of the services rendered;
- Accurately represent clinical problems, observations, interventions, assessments, patient responses, orders, and communication;
- Adhere to the Colorado Board of Nursing's rules and standards of practice governing professional conduct, scope of practice, and documentation;
 - §12-255-101 et seq., C.R.S. - Colorado Nurse and Nurse Aide Practice Act
 - 3 CCR 716-1, Chapter 1 - Rules and Regulations for Nursing Licensure
- Ensure documentation supports the medical necessity of services billed to Medicaid or submitted for prior authorization review.

When HCPF identifies concerns involving deficient documentation or potential violations of professional standards by a licensed nurse, RN and/or LPN, HCPF may refer the matter to the Colorado State Board of Nursing for further review and potential disciplinary action, in accordance with applicable statutes and interagency agreements.

Home Health Agency (HHA) Accountability

HHA's must ensure that:

- Nursing staff are properly trained on medical record keeping, documentation standards, and compliance expectations;
- Nursing staff maintain manageable caseloads so that the nursing staff can provide safe, quality care. This includes ensuring adequate time for nursing staff to meet fundamental nursing standards such as timely and accurate documentation;
- Documentation is routinely reviewed for accuracy, completeness, and alignment with plan of care requirements;
- Systems are in place to detect and correct errors or omissions in clinical records;
- Clinical oversight mechanisms are implemented to promote continuous quality improvement;

- Compliance with Medicaid regulations found in:
 - 10 CCR 2505-10, Section 8.520 - Home Health Services
 - Rule 8.520.3.C: Provider Responsibilities - Requires HHAs to provide skilled care in accordance with professional standards and applicable regulations;
 - Rule 8.520.7.E: Documentation Requirements - Specifies that all services billed must be supported by complete and legible documentation that reflects medical necessity and plan of care adherence.
 - 10 CCR 2505-10, Section 8.540 - Private Duty Nursing Services
 - Rule 8.540.5.C: Provider Responsibilities - Requires HHAs to employ nurses who provide care within professional standards of practice
 - Agencies must also maintain compliance with:
 - 42 CFR § 484.110 - CMS Condition of Participation: Clinical records
 - Colorado Revised Statute § 12-255-119(3)(b)(I)- Professions and Occupations

Agencies are responsible to maintain documentation that supports all services billed and ensure their workforce meets professional and legal standards.

HCPF's Oversight Role

As the state Medicaid agency, HCPF:

- Ensures that services delivered to members are medically necessary, high-quality, and appropriately documented;
- Monitors provider compliance through audits, reviews, and program integrity activities;
 - 10 CCR 2505-10, § 8.076 Colorado program integrity
- Maintains program integrity and addresses fraud or abuse appropriately;
 - 42 CFR § 455.2, and 42 CFR § 455.23 - Medicaid program integrity
- Collaborates with the Department of Regulatory Agencies and the Board of Nursing when concerns regarding clinical practice or documentation arise;
- Ensures the health, safety and welfare of Medicaid members by holding providers accountable for the care they deliver.

Providers are reminded that incomplete or inaccurate documentation may result in denials of requests for prior authorization, fund recoupments, sanctions, or other enforcement actions.

Conclusion

Accurate and thorough nursing documentation is foundational to Medicaid program integrity and high-quality care in any setting. Home Health Agencies and their staff must demonstrate an ongoing commitment to professional excellence and regulatory compliance.

Attachment(s):

None

HCPF Contact:

For questions, please contact the HCPF Home Health Policy Team at:
HomeHealth@state.co.us