Rule No. 560-X-1-.21 Provider Medicaid Records Inspection/Audit

(1) Alabama Medicaid providers shall keep detailed records in Alabama, except as provided in subparagraph (5) Rule No. 560-X-16-.02, that will fully disclose the extent and cost of services, equipment, or supplies furnished eligible recipients. These records will be retained for a period of three years plus the current year.

(2) All orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name. Refer to the individual provider manual chapters for detailed description of what must be included in an order.

(3) Providers shall make all such records available for inspection and audit by authorized representatives of the Secretary of Health and Human Services, Alabama Medicaid Agency and other agencies of the State of Alabama. Provider records and operating facilities shall be made available for inspection during normal business hours.

(4) All providers shall, upon either verbal or written request from any agencies listed above, furnish free of charge a copy of any requested record. If the provider has no copies, the provider must allow the person requesting the copy to check out the original for copying. The provider may require that a receipt be given for any original record removed from his/her premises. If the provider does not furnish records when requested, the Agency may seek a recoupment of payment(s).

(5) When records are requested, providers must send all associated documentation that supports the services billed within the timeframe designated in the verbal or written request. Sometimes that information may come from a visit or test performed earlier than the timeframe of the review. Elements of a complete medical record may include but are not limited to:

(a) Physician orders and/or certifications of medical necessity
(b) Patient questionnaires associated with physician services
(c) Progress notes of another provider that are referenced in your own note
(d) Treatment logs
(e) Related professional consultation reports
(f) Procedure, lab, x-ray and diagnostic reports
(g) Billing provider notes to support the billed date of service
(h) Delivery logs/tickets
(i) Itemized statements/invoices
(j) Prescriptions

(~~5~~6) All providers are responsible for properly documenting any service that has been provided and billed to Medicaid. Documentation must indicate medical necessity and support the coding utilized. Documentation must meet practice standards and be legible for review by persons other than the provider.

(~~6~~7) A mistaken entry in the record shall be corrected by a method that does not obliterate, white-out, or destroy the entry. Corrections to a record shall have the name or initials of the individual making the correction and the date of the correction.

(8) Documentation submitted for review may include amended records. Amended records are legitimate occurrences in the documentation of clinical services and include a late entry, an addendum and/or a correction to the medical record. Amended records must:

- clearly and permanently identify any amendment, correction or delayed entry as such,
- clearly indicate the date and author of any amendment, correction or delayed entry,
- clearly identify all original content, without deletion, and
- be amended prior to claims submission and/or medical record request.

(a) Late entry: A late entry supplies additional information that was omitted from the original entry. The late entry must:

(1) include the date the document is amended,
(2) be amended upon discovery of the omission but no more than 45 calendar days beyond the date of service, and
(3) be entered only if the person documenting the late entry has total recall of the omitted information and signs the late entry.

(b) Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum must:

(1) be timely (no more than 45 days beyond the date of service)
(2) include the current date (the date the document is amended),
(3) include the reason for the addition or clarification of information being added to the medical record, and
(4) be signed by the person making the addendum.

(c) Correction: The original content of the medical record should never be written over or otherwise obliterate the passage when an entry to a medical record is made in error. A correction to the medical record must include:

(1) A single line through the erroneous information, keeping the original entry legible;
(2) Signature or initial,
(3) Date the deletion, and
(4) Statement for the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is

generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Examples of falsifying records include:

(a) Creation of new records when or after records are requested for review,

(b) Back-dating entries,

(c) Post-dating entries,

(d) Pre-dating entries,

(e) Writing over,

(f) Adding to existing documentation (excluding appropriate late entry, addendum and/or correction entries), and/or

(g) Adding late signatures to the medical record beyond the short delay that occurs during the transcription process (45 calendar days beyond the date of service).

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Authority: State Plan, Attachment 4.19-A & D; Alabama State Records Commission; 42 C.F.R. Section 433.32.
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