# DOCUMENTATION AND RECORD KEEPING

## OVERVIEW

This manual includes general documentation and record keeping requirements. Manuals for specific services or providers may contain additional requirements.

## RECORD RETENTION

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. Medical and financial records must be retained for at least six years after the last claim is paid or denied. Records may not be destroyed when an audit or investigation is pending. Medical and financial records must be retained in their original form or in a legally reproduced form, which may be electronic. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.

**Change in Ownership**
If there is a change of ownership of a provider entity, facility, or practice, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. The seller may, by way of a sales contract or a written agreement, transfer this responsibility to the buyer.

**Provider Withdrawal or Termination**
If a provider withdraws or is terminated from the medical services program, records developed during program participation must be retained according the provisions above and provided to South Dakota Medicaid upon request.

## GENERAL MEDICAL RECORDS REQUIREMENTS

Per ARSD 67:16:01:08 health services that are not documented are not covered. Records that are illegible are not considered valid documentation of the service. A provider must maintain a medical record on each recipient which discloses the extent of services furnished. Each page of the record must name or otherwise identify the recipient.

Signature Requirements
Each entry in the record must be signed and dated by the individual providing the care including a notation of their credentials or licensure type. If care is provided by an individual working under the supervision of another who is a participating provider, the supervising individual must countersign each entry. If the care is provided in an institution by one of its employees, the entry need not be countersigned unless the institutional provider is responsible for monitoring the provision of such health care.

The following criteria are used to determine the validity of the signature:

- Services provided or ordered must be signed by the servicing provider;

- Signatures shall be handwritten or electronic;
- Signatures are legible;
- Rubber stamp signatures are allowed in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of their inability to sign their signature due to the disability. The provider is certifying that they have reviewed the document with the rubber stamp.

Electronic signatures in medical records will be accepted in the following formats (not all-inclusive):

- "Electronically signed by";
- "Electronically verified by";
- "Verified by";
- "Reviewed by";
- "Released by";
- "Signed by"; or
- "Approved by".

"Signed but not read" is not acceptable.

In addition, providers using electronic signatures must have systems and software products that are protected against modifications, etc. and should apply adequate administration procedures that correspond to recognized standards and laws.

If the medical record is missing a signature or contains an illegible signature, an attestation statement may be used. The attestation must be signed and dated by the author of the medical record entry and contain sufficient information to identify the recipient. An attestation statement is not acceptable for unsigned physician orders.

Record Requirements

The individual's medical record must include the following additional items as applicable:

- Diagnoses, assessments, and evaluations;
- Case history and results of examinations;
- Plan of treatment or patient care plan;
- Quantities and dosages of drugs prescribed or administered;
- Results of diagnostic tests and examinations;
- Progress notes detailing the recipient's treatment responses, changes in treatment, and changes in diagnosis;
- A copy of any consultation report that is ordered for the recipient;
- A copy of any orders or referrals for services;
- Dates of hospitalization relating to the services provided;
- A copy of the summary of surgical procedures billed to South Dakota Medicaid;
- The date on which the entry is made;
- The date on which the health service is provided; and

- The length of time spent with the recipient denoted by the start time and end time of the service, if the amount paid for services depends on time spent with the recipient such as time-based procedure codes.

In addition to these general medical record documentation requirements, providers must follow service specific documentation requirements stated in South Dakota Medicaid's provider manuals. In the absence of service specific Medicaid documentation requirements, providers must follow Medicare's documentation requirements.

Physician Administered Drugs

The following documentation is required to be maintained in the recipient's medical record when billing for physician administered drugs:

- Full name of the recipient who received the medication;
- Name of the person who administered the medication;
- Date and time when the medication was administered;
- 11-character National Drug Code (NDC) of the medication administered;
- Amount of the medication administered;
- Method by which the medication was administered (pill/oral, an injection); and
- Location of the injection site (when applicable).

## RECORD KEEPING PRINCIPLES

All services provided are to be documented in the medical record at the time they are rendered. Only the attending provider who saw the patient and documented the initial documentation for the visitation in question may amend, correct, or addenda the medical record.

Regardless of origination of the documentation all amendments, corrections or addenda must contain:

1. Clear, permanent, and identifiable information as an amendment, correction, or delayed entry.
2. The identity of the person making the amendment, correction, or entry.
3. Original content without deletion.

When correcting or amending paper medical records the following is required:

1. A single line through original content so that the information is still legible.
2. The signature of person making the correction or amendment along with the date the revision was made. The provider may initial the document if their first and last name is clearly identified elsewhere in the record.

For electronic health record amendments, corrections, or delayed entries the following is required:

1. Distinctly identify any amendments, correction, or delayed entry.
2. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

## ACCESS TO RECORDS

Providers must grant South Dakota Medicaid, designees of South Dakota Medicaid, the Office of the Attorney General Medicaid Fraud Control Unit (MFCU), the Department of Health, the Department of Human Services, and the U.S. Department of Health and Human Services access during regular business hours to examine medical and fiscal records related to health care billed to South Dakota Medicaid. Providers must allow access for unannounced site visits for purposes of meeting requirements of 42 CFR 455.432 and upholding the integrity of the Medicaid program.

Requested information must be provided to South Dakota Medicaid and/or MFCU within 30 days. Information requested by the Department of Health and Human Services must be provided within 35 days pursuant to 42 CFR 455.105.

The investigating agency may photocopy or otherwise duplicate any financial records and any recipient medical records. Photocopying is limited to the provider's premises unless removal is specifically permitted by the provider or the court.

**Recipient Access to Medical Records**
Recipients have the right to inspect, review, and receive a copy of their medical records and billing records that are held by providers covered by the Privacy Rule.

A provider cannot deny a recipient a copy of their records because they have not paid for the services received. However, a provider may charge a recipient the reasonable costs for copying and mailing the records. The provider cannot charge a fee for searching for or retrieving records.

## REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

## QUICK ANSWERS

1. **Who is responsible for maintaining and controlling medical records?**

   The billing provider is responsible.

2. **Does South Dakota Medicaid pay providers for records that we request for review?**

   No.

3. **Does South Dakota Medicaid reimburse providers for the time spent compiling records requested for an audit?**

   No.

4. **Does South Dakota Medicaid reimburse providers for time spent maintaining, documenting, or providing additional copies of a recipient's record?**

   No. ARSD 67:16:01:08 (24) prohibits Medicaid payment for record keeping, charting, or documentation related to providing a covered service, unless specifically allowed.

5. **Do I have to provide a recipient his or her medical records upon request?**

   Yes. Recipients have a right to be provided a copy of their medical record upon request. Recipients also have the right to have their medical records corrected if the record is incorrect.