THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

OFFICE OF THE COMMISSIONER
Medicaid Program Integrity

3601 C Street, Suite 902
Anchorage, Alaska 99503-5923
Main: 907.269.0399
Fax: 907.269.3460

Contemporaneous Documentation FAQs

Q1. Is the 72 hour requirement for documentation of service still in effect?

Effective February 6, 2020, the new requirement for documentation of services is 14 days.

Q2. What about corrections to errors? Most providers have a process of reviewing timesheets and other documentation for errors, then sending the documents back to the employee for corrections.

It is anticipated that a providers' quality assurance process may identify errors outside of the 14 day requirement.

If provider needs to amend or correct a clinical record entry, the following recordkeeping principles apply:

- Clearly identify all original content (do not delete).
- Clearly and permanently identify any amendments, correction, or addenda.
- Clearly indicate the date and author of any amendments, corrections or addenda.

Paper Record

A single line strike through should be used so the original content is still readable. The person amending or correcting the clinical record must sign and date the revision, amendment or addenda (change).

Electronic Health Record

The change must be distinctly identified and there should also be a way to provide a reliable means to clearly identify the original content and the modified content. The person amending or correcting the clinical record and the date of the change must also be documented.

Audit Phase

Once a claim has been selected for audit, the documentation associated with the claim would be evaluated prior to the date the claim was selected.

Q3. Assessments are performed on multiple days and may include a treatment team, when does the 14 day clock start?

Some services, including assessments, are provided over a span of dates; the date of service is the date the service concluded. The 14 day clock will start at the end date of service.

Q4. What if we start the assessment and we conduct an initial interview the client on day one, complete all our collateral contacts over days two and three, and then the client never returns for the follow-up appointment?

At this time the clinician should complete the assessment with whatever information has been completed and include any potential diagnoses or rule out diagnoses.

Q5. Does the 14 day requirement apply to all provider types?

Yes. The 14 day requirement applies to all Medicaid provider types.

Q6. What is the effective date the new 14 day standard?

The effective date is November 13, 2018, for Medical Doctors (MDs) and Doctors of Osteopathy (Dos) and February 6, 2020, for all other providers.

Q7. Hospital licensing standards allow 30 days for completing records. Would this standard apply to the providers who provide professional services within the hospital, or would the providers' own licensing standards apply?

There is a distinction between a facility record, which would be subject to the 30 day rule in accordance with 7 AAC 12.770, and a professional provider. For physicians, nurse practitioners and physician assistants who provide in-patient hospital services, recorded in the hospital chart, but are billed as a professional-fee at fee-for-service rates, the 14 day standard would apply.

Q8. When is the new requirement effective? Is there a retroactive period?

72 hours documentation requirement dates are for dates of service on and after June 7, 2018, through February 5, 2020. Dates of service on or after February 6, 2020, have the 14 day documentation requirement.

For Medical Doctors (MDs) and Doctors of Osteopathy (Dos) the 72 hours documentation requirement are for dates of service on and after June 7, 2018, through November 12, 2018. Dates of service on or after November 13, 2018, have the 14 day documentation requirement.

Q9. How does it work if the notes are not into the database within 14 days?

In accordance with 7 AAC 105.230(d)(7), services must be documented within 14 days of the end of the date of service. If the documentation of the service occurs outside of the 14 day window, the provider should not submit a bill to the department for the service. If a claim is submitted for which the documentation was not completed within the 14 days, it would be considered an overpayment for audit or self-audit purposes.

There is no requirement that the documentation be in an electronic format; as a back-up, providers may use paper, kept in accordance with 7 AAC 105.230.

Q10. Do these regulations require the use of electronic recordkeeping?

No. Regulations allow for, but do not require, the use of electronic records.

Q11. Are any programs being allowed an exemption from this regulation?

No. 7 AAC 105.230(d)(7) applies to all services billed to Alaska Medicaid, Denali KidCare, and the Chronic and Acute Medical Assistance (CAMA) program.

Q12. Does the new regulation require a provider to bill for the service within 14 days of performing the service?

No. In accordance with 7 AAC 145.005(c), a provider has 12 months from the date of service to submit a claim.

Q13. Can I document "start" or "saw client today" and document the details later, or must documentation be completed within 14 days?

No. Initial documentation must include enough documentation to support the service billed in accordance with 7 AAC 105.230.