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72 Hour Contemporaneous Documentation and Provider Self-Audit FAQs

72-Hour Contemporaneous Documentation

Q1. Please clarify the 72 hour requirement for documentation of services; is this a straight 72 hours or is its 72 business hours.

The 72 hour requirement applies to the initial documentation of services. The regulation states 72 hours from the end date of service. This is a straight 72 hours from the end of date of service. An example is the date of service is June 15, 2018, the 72 hour clock starts at 12:00 am June 16, 2018 and is to be documented by 11:59 pm June 18, 2018.

Q2. What about weekends and holidays?

The 72 hour requirement does not allow an extension for weekends and holidays.

Q3. 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 72 hour 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.

Q4. Some providers are required to use a weekly timesheet to record dates of service, shift start and stop times, tasks completed, and case notes/response to care comments. Although these items are generally captured at the conclusion of each shift, the timesheet is not signed and dated by a caregiver until the week of service has concluded. Is this acceptable?

For services that are typically documented through the use of a timesheet, a weekly signature is acceptable. Time in and time out, services provided, clinical notes and all other treatment details must be maintained in accordance 7 AAC 105.230.

Q5. Assessments are performed on multiple days and may include a treatment team, when does the 72 hour clock start?

Some services, including assessments, are provided over a span of dates; the date of service is the date the service concluded. The 72 hour clock will start at the end date of service.

Q6. 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.

Q7. If the documentation of services and initial signature is completed within the 72 hour requirement, can the additional required signatures be outside of the 72 hours?

Yes. If the documentation of services requires additional signatures, they may be obtained outside the 72 hour window.

Q8. Does the 72 hour requirement apply to all provider types?

Yes. The 72 hour requirement applies to all Medicaid provider types unless the provider's professional licensing standards is longer.

Q9. What is the definition of "professional licensing standards"?

For the purposes of 7 AAC 105.230, professional licensing standards are those required under title 8 of Alaska Statutes (State of Alaska licensing standards) or any nationally recognized professional licensure, including but not limited to American Medical Association (AMA), American Dental Association (ADA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Counseling Association (ACA), Standards for Substance Abuse Counselors (SAMHSA), National Association of Social Workers (NASW), American Psychological Association (APA), American Speech- Language-Hearing Association (ASHA), American Occupational Therapy Association (AOTA), and American Physical Therapy Association (APTA).

Out of State Providers

Providers located out of state should comply with the licensing and documentation standards in their own state and any nationally recognized professional standard. If none of the above exist, the 72 hour rule would apply.

Q10. 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 72 hour or their own professional standards would apply.

Q11. Does the 72 hour requirement apply to Care Coordination and/or Targeted Case Management Billing?

Documentation must be completed within 72 hours of the end of the date of service. For monthly services such as targeted case management and care coordination, the date of service is the last day of the month. Dates for face to face and telephone contact must be documented in the record.

Q12. Does the 72 Hour requirement apply to Medicaid Administrative Claiming?

No. The 72 hour requirement applies only to services billed through the Medicaid Management Information System.

Q13. When is the new requirement effective? Is there a retroactive period? Is there any way that the implementation date can be pushed back 3-6 months to allow providers time to learn what is expected and adapt their systems?

The effective date of the regulation is for dates of service on and after June 7, 2018 and forward.

Q14. How does it work if the notes are not in to the database within 72 hours?

In accordance with 7 AAC 105.230(d)(7)the regulations, services must be documented within 72 hours of the end of the date of service. If the documentation of the service occurs outside of the 72 hour 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 72 hours, 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.

Q15. Do these regulations require the use of electronic recordkeeping?

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

Q16. 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.

Q17. Does the new regulation require a provider to bill for the service within 72 hours 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.

Q18. Can I document "start" or "saw client today" and document the details later, or must documentation be completed within 72 hour?

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

Q19. Our clinicians are often backlogged and keep short-hand summaries then catch up several weeks later, will the short-hand summaries count toward the 72 hour requirement?

Initial documentation must be sufficient to support the service billed in accordance with 7 AAC 105.230 and 7 AAC 135.130.

Q20. Is it okay if a provider dictates notes immediately and the completed transcription comes to the office once a week to be reviewed and signed?

Yes, as long as the dictation occurs within 72 hours of the end date of service. Dictation is considered initial documentation. The date of dictation and transcription must be documented.

Q21. Therapeutic foster parents write their notes daily, then bring them to the office weekly. The notes are then scanned into our records. Is this okay?

Yes, as long as the initial documentation occurs within 72 hours and is sufficient to support the service billed in accordance with 7 AAC 105.230.

Q22. When an evaluation and management (e/m) service level is determined by time being considered the key or controlling factor to qualify for the level of e/m service, are start and stop times required in the documentation?

In those instances where time is the determining factor in with e/m code is billed, the e/m service would be come a time based code and start and stop times should be documented.

Q23. There are times when our EHR is unable to capture the patient's records, due to a technical glitch, within the 72 hour contemporaneous documentation requirement. How can we properly bill for the services in this situation?

In times where an EHR is unavailable, the provider has the option to document on paper, retain the original documentation in HIPAA compliant standards, and retain the document within the required timeframes; all according to 7 AAC 105.230.

Q24. Due to our EHR electronic signature limitations, there are times when a clinical note is completed within the 72 hours from the date of service, however the signature was captured after the 72 hour requirement. Will this note be billable? Is it enough to have the note completed but unsigned?

Full clinical documentation must be completed and signed within 72 hours. If your agency utilizes an EHR this will include the use the full electronic signature and entering the provider credentials. When the

documentation goes through the Quality Assurance process, if changes are needed, the provider can make any necessary changes using the process of addendums to the original note. The addendum should note that the reason for the correction is due to internal Quality Assurance. See Q3 in the FAQ for proper addendums documentation.

Provider Self-Audits

Q1. The self-audit process referenced in 7 AAC 160.115 appears to apply to medical practices. I own a 12-bed assisted living home; does this biennial requirement apply to me?

Yes. The self-audit requirement applies to all enrolled Alaska Medicaid providers.

Additional information about self-audits is available at http://dhss.alaska.gov/Commissioner/Pages/ProgramIntegrity/default.aspx.

Q2. When do I have to start performing self-audits? Do I need to submit one now for 2016 & 2017 or is it after June 2018?

Alaska Medicaid providers are required to complete a self-audit once every two years. The first self-audit is due on or before June 7, 2020. For example, a provider may choose to conduct a self-audit on calendar year 2018 claims. To account for timely filing, the provider must wait until the end of 2019 to begin the review. A sample of claims would be reviewed for compliance with regulations and due no later than June 7, 2020.

Q3. An auditor of one of the programs discovered that the link to the CMS self-audit toolkit *Conducting a Self-Audit: A Guide for Physicians and Other Health Care Professionals, February 2016* referenced in the regulations does not work. How can I access the toolkit?

The CMS self-audit toolkit is available at http://dhss.alaska.gov/Commissioner/Documents/medicaid/CMS-Self-Audit-Booklet-Feb-2016.pdf. The document is large, and may take several minutes to load. The link to the CMS self-audit toolkit is also available on the Medicaid Program Integrity webpage (http://dhss.alaska.gov/commissioner/pages/programintegrity/) under the *Self-Audit Resources* section.

Q4. Will self-audit assistance or training be available to providers and billers?

Self-audit guidance is available at http://dhss.alaska.gov/Commissioner/Documents/medicaid/CMS-Self-Audit-Booklet-Feb-2016.pdf. Additional self-audit information, including the Provider Self-Audit Attestation form, is available at http://dhss.alaska.gov/commissioner/pages/programintegrity/default.aspx. The new self-audit regulations are available at http://dhss.alaska.gov/commissioner/pages/programintegrity/default.aspx.

Q5. How frequently must self-audits be completed?

Self-audits must be completed once every two years.

Q6. How many claims should be reviewed, and over what date spans?

The number of claims (sample size) is determined by a statistically valid random sample, using RAT-STATS or other statistical software https://oig.hhs.gov/compliance/rat-stats/index.asp. Audits span one calendar year of paid claims.

Medicaid Program Integrity Resources

- Medicaid Program Integrity webpage

  http://dhss.alaska.gov/Commissioner/Pages/ProgramIntegrity/default.aspx

- Provider Self-Audit Attestation form

  http://dhss.alaska.gov/Commissioner/Documents/medicaid/PV-Self-Audit-Attestation.pdf

- Office of Inspector General Statistical Software RAT-STATS

  https://oig.hhs.gov/compliance/rat-stats/index.asp

- Medicaid Program Integrity email address

  QAPIProgramIntegrity@alaska.gov

- New Medicaid 72 Hour Contemporaneous Documentation and Provider Self-Audit regulations:

  http://dhss.alaska.gov/commissioner/pages/programintegrity/default.aspx