Iowa Medicaid
IOWA HHS

Frequently Asked Questions (FAQ)

SERVICE DOCUMENTATION

This FAQ was created to assist providers in understanding IAC 441-79.3, service documentation expectations, in addition to the recorded training from September 20 and 21, 2022. Changes to documentation requirements were outlined in ARC 6419C and were in effect as of September 16, 2022. This aid was prepared as a service to the public and is not intended to grant rights or impose obligations. This aid may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. Use of this aid is voluntary. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

FAQ CREATED: 10/4/2022 | UPDATED: 10/10/22 | ADDITIONAL UPDATES: 2/27/23*

GENERAL QUESTIONS

QUESTION	ANSWER
Who is required to follow IAC 441-79.3 Maintenance of records by providers of service? **Who is required to implement IAC 441-79.3 and the changes effective 9/16/2022 to 79.3(2)c(3) which is: Medical (clinical) records, Components, Service documentation?**	All providers of medical and health services that are charged to the Medicaid program are required to comply with the requirements of 79.3.
What services are impacted by the changes to Iowa Administrative Code?	The amendments to 441 79.3 impact all medical and health services that are charged to the Medicaid program. Removal of the requirement for narrative documentation for each shift of service will be most impactful to Home and Community Based Services (HCBS).

*Anything marked with an asterisk was updated on February 27, 2023.

QUESTION	ANSWER
When will IAC be updated to reflect the new changes?	Yes, the administrative rules will be updated to reflect the adoption of the amendments and currently have an updated date of 10/5/2022. The Administrative Rule Change (ARC 6419C) document with the explained changes can be found here: https://www.legis.iowa.gov/docs/aco/arc/6419C.pdf
What are the changes?	The following changes were proposed and accepted from Administrative Rule Change (ARC) 6419C found here: https://www.legis.iowa.gov/docs/aco/arc/6419C.pdf (1) Removal of the requirement of a narrative unless there are incidents, illnesses, unusual or atypical occurrences that occur during service provision. (2) The Medication administration record (MAR) and mileage logs are considered a part of the service documentation. (3) Member response requirements were removed. (4) For 24-hour care, the phrase, "the person who provided the services" was removed because the following two items are still required: • The first and last name and professional credentials, if any, of the person providing the service. • The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity. (5) IAC 79.3(2)"d" in the introductory paragraph to medical record - basis for service. The health care provider should include all records and documentation that substantiate the services provided to the member and all information necessary to allow accurate adjudication of the claim. Additionally, documentation requirements must meet the professional standards pertaining to the service provided. See the recorded training regarding these changes here: https://hhs.iowa.gov/Providers/tools-trainings-and-services/CBT-for-LTSS/Archive
Can we continue to use narrative if we chose? Can we keep narrative for certain tasks/activities?	Yes. Agencies can set their own policies around narratives if the documentation substantiates the services provided and follows rules outlines in IAC 441-79.3.
Is time spent on each intervention required?	This is not required, but agencies could choose to include the information if they felt it was needed.

QUESTION	ANSWER
Is narrative documentation required? What if nothing unusual or atypical occurs during the provision of services was does the narrative look like?	Narrative documentation is only required for any incidents or illnesses or unusual or atypical occurrences. If there are no incidents, illnesses, unusual or atypical occurrences during the provision of services, narrative documentation would not be required unless narrative documentation is part of the professional standards pertaining to the service provided.
Can abbreviations, shorthand, or acronyms be used in daily service narrative documentation?	Providers are encouraged to avoid the use of abbreviations, shorthand, or acronyms in service documentation unless an abbreviations and acronyms list is provided in the medical record.
If a minor or major incident report is required, can staff check a box in the service documentation that one has been completed and refer to that document? **Does having an incident report notation in the documentation count as a narrative for incidents?**	No, a checkbox or a notation is not enough information if there is an incident, illness, unusual even, or atypical occurrences. There will need to be an explanation of what occurred in a narrative.
Similar to narrative documentation, is it sufficient to do a count or pass/fail for goal progress or does it require some kind of accompanying narrative? For additional documentation can it be as simple as, "reminded to take meds. Took meds." and then check the "Pass" box.	If an agency creates and maintains a service plan in conjunction with the person-centered plan from the case The data collection methodology should be detailed in the individual plan for the skill being taught. In most cases a check box indicating the member's performance on the goal objective would be sufficient to demonstrate that the training plan was implemented and documented.
Without narrative needed, is each staff expected to complete a document or section, or can it be ongoing during the day? Does each shift or staff need to sign the document?	Any staff who completes documentation needs to sign and date their contribution. This could be ongoing throughout the day but signed when the staff completed their shift indicating the end of any contribution to services or the note.
We have a Night Owl program in place at one of our homes. Is a narrative needed since it's not 24/7 supervised?	* No. This answer is not only specific to Night Owl. Narrative documentation is only required for any incidents, illnesses, or unusual/atypical occurrences.

QUESTION	ANSWER
Is it likely that narrative documentation will remain necessary to show medical necessity?	No. Removal of the requirement for narrative documentation for each shift of service will be most impactful to HCBS providers in this rule. The amendment to the rule did not remove the provider's requirement to ensure documentation adequately substantiates that the service was provided and meets the professional standards for the service being delivered, but this may be done through ensuring routine services are completed and documented in checklists or other formats. 441-79.3(2) "c" (3) requires: • The record for each service provided shall include information necessary to substantiate that the service was provided. • Documentation must adequately substantiate the medical necessity and that the services were rendered. 441-79.3(2) "d" requires: • The healthcare provider should include all records and documentation that substantiate the services provided to the member and all information necessary to allow accurate adjudication of the claim. • Documentation requirements must meet the professional standards pertaining to service(s) provided.
For those of us who utilize EMRs/EHRs, would you suggest having different types of service documentations staff can utilize that best match the service that was provided? Or just use one form for all? Also, is there one form that you suggest works best for certain services such as HBH Hourly or SCL?	The service documentation that is captured by the EHR/ EMR must be individualized to the services and supports identified in the member's person-centered service plan and meet the requirements of 79.3(2)"c"(3). The type and contents of the form that an agency chooses to use for service documentation may be individualized to the agency's needs based on policy and procedures that they implement. Iowa Medicaid cannot say if one form or multiple forms are more appropriate. Please feel free consult with your HCBS specialist to discuss your specific process for documentation.
Do you have advice or examples of how providers establish/substantiate medical necessity without the use of narrative?	See sample documents provided with the service documentation training found on the training archive here under "Handout": https://hhs.iowa.gov/Providers/tools-trainings-and-services/CBT-for-LTSS/Archive

QUESTION	ANSWER
Would the authorization from the case manager for the provided services suffice to demonstrate medical necessity for the particular service?	Medical necessity is referenced in a few areas of IAC and is a requirement of the medical/clinical record. An authorization is an important part of medical necessity in the medical/clinical record but is not a part of service documentation substantiating the services provided. The service documentation must be individualized to the services and supports identified in the member's person-centered service plan and meet the requirements of 79.3(2)"c"(3) which includes the requirement that each record of service should include the information necessary to substantiate that a service was provided.
Does the staff shift time need to match exactly when member came/went from service? For example: Staff worked 12p - 4pm but member arrived home at 12:15pm and left again at 3:15 pm. How should staff shift times and member alone times be documented?	Yes. The service record must include the complete time of the service, including the beginning and ending time if the service is billed on a time-related basis (such as a 15-minute unit). In the example provided the service encounter begin time would be recorded as 12:15pm when the member began receiving the service and the encounter end time would be recorded as 3:15pm when service encounter ended. Providers may not bill for time when the member was not present to receive the service unless the member is receiving a service that is reimbursed at a daily per diem for 24-hour services such as with the Intellectual Disability Waiver Daily Supported Community Living (SCL) service.
If staff shift times are noted in electronic note but member leaves in the middle of staff's shift, would narrative still be needed to document the times the member received services?	Yes. The service record must include the complete time of the service, including the beginning and ending time if the service is billed on a time-related basis.

MILEAGE LOGS

Question	Answer
If mileage logs, as part of the service record, identify locations traveled during the shift, do we have to specifically identify the location of each activity?	No. Mileage logs can be submitted with HCBS review materials to indicate the place of service. These would need to be organized in a way that the members impacted could be identified.

QUESTION	ANSWER
If the service documentation identifies the locations of the services that took place do we still need to include mileage logs with odometer readings, trip totals, and to/from locations in the service doc?	Noting the locations of services does not take the place of mileage logs. The parameters of the mileage log have some flexibility as long as they meet the rule ("6. Mileage log. The name, date, purpose of the trip, and total miles for transportation provided as part of the service."). Mileage logs may be on paper, as in the example provided during the Service Documentation and Service Monitoring presentation in September 2022. Some organizations utilize their EHR system to track mileage. Others utilize fleet management software. Providers are encouraged to use their discretion with the format to meet the Medicaid rules.
Do day habilitation and pre-vocational services need to initiate a mileage log or is it only for residential services (going back to the date when transportation funding was rolled into the daily waiver rate)?	Day habilitation and pre-vocational services under both waiver and habilitation services have transportation as a component of the services. If there is transportation, there would need to be a mileage log. *Additional services that have transportation listed as a component of services include (but are not limited to): waiver and habilitation supported employment, home-based habilitation, supported community living, CDAC, and respite.
Are mileage logs required if you provide transportation under CDAC waiver services? We don't bill mileage as part of CDAC.	When transportation is provided as a component of the CDAC service, the transportation provided can be captured on the CDAC Daily Service Record (N11 – Essential transportation) or in the Electronic Visit Verification (EVV) system. A specific mileage log would only be needed if the documentation did not capture the requirements: name of the individual, date, purpose of the trip, and total miles for transportation provided.
Does narrative documentation need to include a checklist item stating something like, "Transportation provided. See Mileage Log."?	No. Mileage logs can be a part of the service records. The service record should include the information necessary to substantiate the scope of services delivered. Participation in the community should be reflected in the service record.
Is the mileage log in addition to the GPS address or in place of (with EVV or other electronic record keeping)?	The GPS does not replace a milage log. A mileage log would only be needed in addition to the EVV if the CDAC provider was providing essential transportation and was not able to capture it in the EVV or daily service record. Documents for the mileage log need to include the name of the individual, date, purpose of the trip, and total miles for transportation provided as part of the service are required to be documented for those services where transportation is provided as a component of the service.

QUESTION	ANSWER
Do we need mileage logs for transportation provided during hourly SCL?	Yes. When the provision of the transportation is an authorized stand-alone service, or a component of the service delivered, the mileage log substantiates that the transportation identified in the member's service plan was provided.
Would total miles be enough for mileage log for SCL service doc since shift times and locations are already captured?	Providers will need to ensure that all components of the Mileage Log are present in records in accordance with 44179.3(2) "c" (6.). Mileage log. The name, date, purpose of the trip, and total miles for transportation provided as part of the service.
When documenting mileage, what times should be included? Ex: Time left and time returned, or time left and arrival at different location.	Trip start and stop times are not required to be documented on the mileage log.
How does the mileage fit into the member file if the agency has multiple member names on the document? How do you document transportation for multiple members? **When filing/storing records, how would you store mileage sheets if transporting a group of individuals at the same time?**	Typically, HCBS providers that provide transportation as a component of another service maintain a log in the vehicle used to transport members, logging the date and time of the trip, the type of trip, names of the member's transported, the origination location and destination location and total miles. The storage of these records would be up to the agency. Ensure that policy and procedure address this. Logs may have more than one member name and do not have to stored in the member file. When staff are using their own vehicle to transport the agency should have a policy and procedure to address how that transportation is logged. The mileage logs are utilized to substantiate the services provided and to validate that the member is being transported during the service when transportation is a component of the service.
Since the mileage log is part of the service record and knowing that the documentation for goals and supports identifies locations, do we need to answer reason for trip on the mileage log?	Yes, you must document the purpose of the trip. The purpose of the trip must be documented on the mileage log in accordance with 441-79.3(2) "c" (6.) Mileage log. The name, date, purpose of the trip, and total miles for transportation provided as part of the service. A cross reference of goals and supports would not clearly identify the goals/supports provided on that trip, as they may have multiple goals or objectives.

QUESTION	ANSWER
Do Title XIX numbers and Service codes need to be on the mileage log?	When transportation is provided as a component of a service, the mileage log only needs to include the member's name. When the provider is delivering transportation as a standalone service, the transportation specific service HCPCS code is required on the mileage log.
Do we need to keep track of mileage if we contract with an outside service for transportation? This agency pays for a service to transport our individuals from their HCBS homes to our day habilitation facility. Wondering if we need to document that mileage and transportation?	Yes. The provider making the charge to Medicaid for the services provided is responsible to ensure that the service documentation meets all the requirements of 441 79.3(2) "c".
Medical Record " Clinical Record" (Slide10 #6) Says that Prior Authorizations required for Medicaid payment. What documentation does this include? A copy of the request form? A copy of the approval letter from MCO? Just a record of the requested date and PA#?	When a service charged to the Medicaid program requires Prior Authorization (PA), the authorization is a part of the clinical record. This may be a Notice of Decision (NOD), Notice of Action (NOA) or other document received from Iowa Medicaid or the member's MCO authorizing the service.
Why do I need to document transportation provided during service provision?	When the provision of the transportation is an authorized stand-alone service, or a component of the service delivered, the mileage log substantiates that the transportation identified in the member's service plan was provided.

PROFESSIONAL STANDARD

Question	Answer
Will this impact Chapter 24 requirements for narrative documentation?	No. The standards outlined in IAC 441-24 are a separate chapter from 79.
Is there an example of a professional standard for medical supports provided in an HCBS?	There is not a set professional standard for all medical supports provided across HCBS because all services do not incorporate medical services in the scope of services. Home Health Agencies delivering HCBS Home Health Aide, Interim Medical Monitoring or Treatment (IMMT) or Nursing services would be expected to document in accordance with 42 CFR 484.

QUESTION	ANSWER
Give an example of a "professional standard" that requires documentation.	Mental health providers with licenses have ethics, accrediting entities, and professional best practices that they would have to refer to along with IAC 441-79. Inpatient psychiatric care would need to follow rules of inpatient care. Psychiatric Mental Institution for Children would still need to follow professional standards set by accreditations and any other rules and regulations such as those set by the Department of Inspections and Appeals. Chapter 24 accredited agencies have service documentation standards in IAC 441-24.
Which services require narrative documentation as part of its professional standards (page 26 of the Power Point)?	Examples of services that require narrative documentation as part of the professional standards (at the time of this FAQ) include mental health services, inpatient and outpatient hospital services including substance abuse treatment services. Another example is Home Health Agency services which also require narrative documentation to substantiate the services provided in accordance with the treatment plan. In accordance with the Federal Home Health Agency Regulations at 42 CFR 484.50 (d)(5)(ii) and (iii). The clinical record should reflect: • Identification of the problems encountered; • Assessment of the situation; • Communication among HHA management, patient caregiver, legal representative, and the physician responsible for the plan of care; • A plan to resolve the issues; and • Results of the plan implementation.

QUESTIONS SPECIFIC TO HCBS

Question	Answer
Are the start/stop times for each med or pass required?	No, these are not required by IAC 441-79.3.
Do we need to document on a Medication Administration Record (MAR) if we do not dispense, or administer medication during service provision?	No. Documentation on a MAR is only required when the medications are dispensed or administered during service provision. A MAR is not required if medication administration is not a part of the services provided.
Does documenting on a MAR no longer need any other type of documentation such as narrative?	A MAR did not previously require narrative. This has not changed. See the Power Point from the September 2022 service documentation for an example of a MAR.

QUESTION	ANSWER
If the member administers their meds independently and dispenses their meds independently but we observe and correct them, does that require completing a MAR?	The code in 441-77.37(5) requires that if the provider stores, handles, prescribes, dispenses, or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. If the provider does not store, handle, prescribes, dispense, or administer prescription or over-the-counter medications as a component of the service being delivered then a MAR is not required.
*** Is there a formal definition of a MAR in IAC standards for providers?**	There is no formal definition of MAR in Medicaid rules. According to IAC441-79, MAR must include the name, dosage, and route of administration of any medication dispensed or administered as part of the service in their service documentation. The preference and best practice would be a that each member has a formal record that is easily audited by the provider and others to ensure proper medication administration is occurring.
*** Does a MAR have to be a document separate from the service documentation?**	No. Service documentation and the administration of medication can be documented in the same place or on the same record. If medication is tracked on the service documentation, the provider would need to audit all service notes/records to ensure meds are being administered on a regular and ongoing basis. There would need to be consideration for evidence of the initiation and discontinuation of a medication and general doctors' orders. Consideration should be given to how the agency trains staff on the individual member medication protocols if not using a mar (individuals may have different documentation or needs if not consistently using a MAR). An agency would need to ensure that medication is administered as prescribed and be able to provide evidence of this for any review.

RECORD MONITORING

Question	Answer
What are the expectations for monitoring progress?	In 79.3(2) Medical (clinical) records there is an expectation that the outcome of service is documented. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis. The CM, TCM, CBCM, or IHH monitors that the services in the person-centered service plan are adequate, including the member's progress toward achieving the goals and actions determined in the person-centered service plan.

QUESTION	ANSWER
How frequent are the CM reviews of service doc supposed to be occurring? Is this process for CMs new?	This is not a new requirement. The CM, CBCM or IHH may choose to complete the regular review of the member's record during their quarterly face-to-face visit with the member or at any other regularly scheduled interval.
On one of your examples of documentation it has a section "Reviewed By" (name and credentials) who does this refer to have completed the review?	This section could be used for internal quality oversight and the person reviewing should be articulated in agency policy or procedure. See the handout and examples under the training Archive here: https://hhs.iowa.gov/Providers/tools-trainings-and-services/CBT-for-LTSS/Archive
We cannot encrypt a PDF file so cannot ensure that the file is HIPAA compliant if we attach and send through email. So, is a provider required to mail documentation to the CM for review or can we make it available to the CM at our office?	A provider is not necessarily required to mail documentation. Please arrange with the case manager. The agency office is an acceptable meeting location to review documentation if needed. That will be up to the case manager to schedule. * Review of materials can occur in the agency office.
*** Can the review of the member record be done verbally between the Case Manager and the Agency?**	No. Case Managers should be going onsite to review provider documentation unless the provider uses an electronic service record and agrees to grant remote access to the records. Case Managers should review service documentation during the quarterly face to face visit to assess the member and their place(s) of service or arrange with the member's direct service provider a mutually agreeable date and time for the Case Manager to review the member's service record.
How is the CM or other going to address privacy is reviewing these items in a residential home with multiple members?	Case managers and agencies/providers will need to coordinate to assure necessary privacy when monitoring services or meeting with members they serve. Members have choice in the meeting locations and times when they are involved and can communicate these choices to the case manager.

QUESTION	ANSWER
What is the expectation for how far back the review of service documentation should cover?	When completing the service documentation review as part of service monitoring activities, the case manager is expected to review at a minimum the member's service record and any entries that occurred in the record for the past 30 days prior to monitoring visit. This may vary depending on the frequency of service delivery. When completing the service documentation review as part of service monitoring activities, the case manager is expected to review at a minimum the member's service record and any entries that occurred in the record for the past 30 days prior to monitoring visit. This may vary depending on the frequency of service delivery. On slide 34 of the service documentation and service monitoring training, the department has included the details of the type of documentation that the Case Manager should be reviewing quarterly at a minimum.
Why was monitoring of service not given to the MCO to complete?	The MCO community-based case managers will complete the service monitoring for HCBS Waiver members served within their organization and the Integrated Health Home will complete the service monitoring for HCBS Habilitation and Children's Mental Health Waiver service monitoring activities are included in the Intensive Care Management (ICM) Per Member Per Month (PMPM) payment received by the IHH.
How should it be addressed when agencies are not able to grant access to documentation away from their office location for review? **Many agency office locations are not in the county the CBCM/CC serves. How should they go about scheduling this monitoring?**	The case manager is expected to schedule a separate time with the direct service provider to review the member's service record. This would mean that the case manager would need to go onsite to an office location to get access to documentation and will need to schedule time with assigned provider staff.
*** In the event materials were reviewed in the office and copies of the materials were not submitted, but original documentation or electronic documentation is reviewed, how do the Case Managers indicate that the review occurred?**	Case Managers are not expected to keep copies of the service provider's member service records in the Case Management File. A notation in the member's record indicating the completion of a documentation review, notes of what was reviewed, the Case Manager's observations, and findings of the review would be sufficient to demonstrate the monitoring requirement was met. The items we expect to see in the Case Management File would be those items listed in 441 79.3(2)"d"(33).

QUESTION	ANSWER
What is the expectation for monitoring services that do not include direct care such as home delivered meals, personal emergency response services (PERS) or chore services?	The Case Manager discusses these services with the member/ guardian/family to determine whether the services are being received in the amount expected and whether the member is benefiting from the receipt of the services. They communicate with the service provider to determine if the service is having the intended impact and if any changes are needed. The case manager also makes a service entry noting the responses and any concerns or gaps in services in the member's record and work with the member/representatives and provider to remediate the issues services.
How can or should the CM, CBCM or IHH obtain these documents to review?	The CM, CBCM or IHH will complete the member record review in either the member's home, place of service or the service provider's office as applicable. The CM, CBCM or IHH may choose to complete the regular review of the member's record during their quarterly face-to-face visit with the member or at any other regularly scheduled interval.
What is the expectation or course of action if the CM thinks services are not being delivered appropriately?	If during service plan implementation monitoring the CM, CBCM or IHH identifies any of the following areas of concern they will contact the service provider to determine what actions are being taken and if additional remediation is required: 1. An unmet service need or risk 2. An unreported critical incident, or pattern of incidents 3. A medication error or pattern of medication errors 4. Environmental issues such as accessibility, safety, security, cleanliness 5. Health issues such as medication management, adequate food supply (are their groceries in the home, is there spoiled food in the fridge) 6. Lack of or insufficient record of the member's finances. Expenditures for which there are no receipts and no evidence of items purchased. 7. Lack of or insufficient service documentation to support the services authorized 8. Any other areas of concern in the member record

QUESTION	ANSWER
Who should be notified if the CM, CBCM or IHH thinks services are not being delivered appropriately? Should services be ended?	When identifying concerns or issues during a service record review, the CM, CBCM or IHH will first contact the direct service provider responsible and address the issue. The CM, CBCM or IHH should actively work with the direct service provider to put in place timely remediation required to resolve the issue or concern. This may include a variety of remediation activities including, but not limited to, amending the service plan, additional services, changes in schedules and environments, staff training, etc. If the CM, CBCM or IHH determines that the provider is unwilling or incapable of implementation of the expected remediation, they will report the quality concern to the HCBS QIO or the member's MCO for further investigation.
For individuals that are receiving services documented in the EVV system, if the agency is able to provide the case manager electronic access to the member's service record in the EVV system, can the staff review documentation and follow-up with providers on concerns they see in their office?	Yes, when records are not stored in the location where services are delivered, the case manager may view those records from their office location with a log-in (if that is possible) or in the provider's office. A provider choosing to implement electronic service documentation does not change the service monitoring requirements for the case manager. The case manager is expected to review the service record regardless of whether it is electronic or in paper form or a combination of both.
What if a service provider refuses to provide the records or access to the records in a timely manner?	When signing the Medicaid Provider Agreement, the provider attests that the Department and/or Iowa Medicaid, Federal employees, and/or authorized representatives shall be given access to the business or facility and all related member information and records. This information and records include claims records and information regarding payments claimed by the Provider for furnishing services under the Provider Agreement. Providers refusing to grant access to member information and records are subject to Sanctions pursuant to rule 441— 79.2(3)(249A): • A term of probation, termination from participation, or suspension from participation in the medical assistance program. • Suspension of payments in whole or in part. • Prior authorization of services. • Review of claims prior to payment.

QUESTION	ANSWER
For IHHs overseeing HCBS CMH Waiver or State Plan HCBS Habilitation service plan implementation, can other staff in the IHH (e.g. supervisor, team lead, administrative staff, nurse, peer support) review the service provider documentation or only care coordinators?	Service monitoring is the responsibility of the Care Coordinator as identified in the definitions for case management in 441 IAC 90.1. "Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination provided to the habilitation and children's mental health waiver populations. "Case manager" means the staff person providing all categories of case management services regardless of the entity providing the service or the program in which the member is enrolled, including IHH care coordination.

CORRECTIONS TO THE SERVICE RECORD

Question	Answer
What date do I use if the date of documentation is different than the date of service provision? E.g., forgot to document in the narrative that an CIR occurred and need to add a week later?	Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record. The date that the new entry is added into the service record is the date that is recorded with the person's signature for the information added. Example: If you are making an addition to service documentation for September 1, 2022, on October 2, 2022, you would make the correction to the entry, sign, and date the entry October 2, 2022.
Can I create missing documentation or change documentation to prepare for an audit?	The creation of missing documentation to prepare for an audit would not be acceptable and may be viewed as Medicaid fraud. Iowa Medicaid expects the documentation to occur at the time the service is delivered or shortly thereafter. Providers should comply with this requirement and complete documentation in a timely manner. Understand that anything beyond 48 hours could be considered unreasonable. It's unreasonable to expect a provider to recall the specifics of a service long after the service was rendered. Entries should not be made in advance.

QUESTION	ANSWER
What are providers to do if staff quit prior to completing their documentation or delete documentation, w/ no recourse to get that staff to make corrections?	If documentation is not complete, you may not bill for that service. If billing occurs, but documentation is not present and found in internal quality processes, the agency would contact Medicaid Program Integrity Unit to make a self-report. A payback may be needed and would be determined after review. If the record needed corrections that were not completed before the staff left, there could be a person assigned to make that notation in the member file or an addendum to the note to indicate this situation. The person making the note would ensure that their name, date, and signature was present on the addendum. Agencies should track the corrections or feedback they are giving employees so this can be reviewed if needed in these situations.
How do I make corrections to documentation if an error is discovered during a quality assurance review?	Instructions can be found in IAC 441-79.3(2) Medical (clinical) records, e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement. Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service. A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable. Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record. If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.