Title 23: Medicaid

Part 200: General Provider Information

Chapter 1: General Administrative Rules for Providers

Rule 1.3: Maintenance of Records

A. All professional, institutional, and contractual providers participating in the Medicaid program must:

1. Maintain all records substantiating services rendered and/or billed under the program, and

2. Upon request, make such records available to representatives of the Department of Health and Human Services (DHHS), the Centers for Medicare and Medicaid Services (CMS), the Division of Medicaid, or the Mississippi Medicaid Fraud Control Unit (MFCU) in substantiation of any and all claims.

B. The Division of Medicaid defines medical records as documentation supporting medical services which fully disclose the extent of services, care and supplies furnished to a beneficiary and support claims billed.

1. Medical records must be legible, appropriate, and correct. All entries within a medical record should be written legibly to ensure beneficiary safety and appropriate billing and/or reviewing.

2. All information contained within a medical record must be written, entered or otherwise compiled on appropriate provider documentation forms.

3. All entries within the medical record must be made without a space between entries.

4. All entries must be made in a permanent form and cannot be in pencil.

5. Corrective tape, corrective liquid, erasers or other obliteration methods cannot be used to remove or change information in the medical record.

6. A medical record is a legal document and illegal to tamper with or falsify.

7. Entry corrections in the medical record must be documented as follows.

a) Draw a single line through the error, to ensure the error entry is still legible.

b) Document the current date and time the error was lined through and initials of who lined out the entry.

c) Document the correct information as a new entry on the next available line or in the

next available space including:

1) The date and time of the new entry,

2) The date and time the correct information occurred, and

3) The details of the correct information.

d) Do not use corrective tape, corrective liquid or other obliteration methods to change or erase any part of the medical record.

8. Late entries are defined as entries that are not completed in the same business day as the date of service and must be documented as follows:

a) Identify the new entry as a "late entry" in the medical record.

b) Document the current date and time when the late entry is actually being written in the medical record and not the date and time the event/incident actually occurred.

c) Document the late entry event/incident and refer to the date and time the event/incident actually occurred within the late entry.

d) Document information as soon as possible.

e) Do not use corrective tape, corrective liquid or other obliteration methods to change or erase any part of the medical record.

C. Medicaid providers must maintain auditable records that substantiate the payment of claims submitted to the Division of Medicaid.

1. The Division of Medicaid's staff must have immediate access to the provider's physical service location, facilities, records, documents, books, prescriptions, invoices, radiographs, and any other records relating to licensure, medical care, and services rendered to beneficiaries, and billings/claims during regular business hours, defined as 8 a.m. to 5 p.m., Monday – Friday, and all other hours when employees of the provider are normally available and conducting business of the provider.

2. The Division of Medicaid's staff must have immediate access to any administrative, maintenance, and storage locations within, or separate from, the service location.

3. The Division of Medicaid does not reimburse providers for the provision of or access to records substantiating claims submitted to the Division of Medicaid.

D. If a provider's records do not substantiate services paid under the Mississippi Medicaid program the provider must refund to the Division of Medicaid any money received from the Medicaid program for such unsubstantiated services. If a refund is not received within thirty

(30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

E. Providers must retain medical records for a minimum of five (5) years or longer as required by federal or state law.

1. All providers required to file a cost report must keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

2. All providers not required to submit a cost report must keep and maintain books, documents, and other records as prescribed by the Division of Medicaid in substantiation of its claim for services rendered to Medicaid beneficiaries, for a period of five (5) years from the date of service or until after the date all audit findings are resolved, whichever is later.

3. Providers whose cost reports are selected for audit must keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports until such time as the audit and/or any related appeals are finalized.

4. Providers who are required to pay assessments must keep and preserve books and records as necessary to determine the amount of the assessments for which it is liable for no less than five (5) years.

5. Coordinated Care Organizations (CCOs) must keep and maintain books, documents and other records as prescribed by the Division of Medicaid for a period of no less than ten (10) years or until all issues are finally resolved whichever is later.

6. The Division of Medicaid is entitled to full recoupment of the amount paid to any provider of a medical service who has failed to keep or maintain records as required.

7. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil and monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

Source: 42 C.F.R. § 422.504; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129, 43-13-145.

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