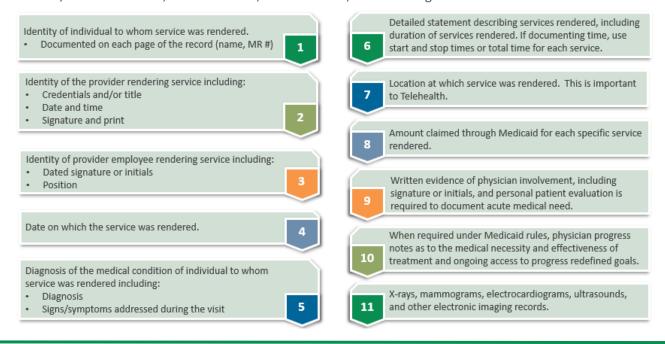
Indiana FADS Provider Education





Medical Records Documentation Regulations

Medical and/or other records, should include, at a minimum, the following information and documentation:



Most Common Documentation Errors

The following is a list of commonly made documentation errors when keeping medical records that can be prevented:

Missing documentation

 Provider fails to submit medical records or other required documentation to support the services billed

Illegible documentation

 Handwritten notes, orders, or prescriptions cannot be read

• Insufficient documentation

- Records that do not support the services billed, or key elements are missing, such as signatures, dates, or required documentation for the specific service
- Missing patient demographic information on each page including, patient identification (patient name, MR #), date of service, and location of service

Non-compliance with State or Federal regulations

Documentation that does not meet specific state
Medicaid or Federal requirements, or specific policy

No proof of delivery

 For durable Medical Equipment (DME) providers, there is no proof of deliver to the beneficiary

No prior authorization

 Services requiring prior authorization, but documentation does not show authorization was obtained

Incorrect coding

 Services billed do not match the documentation, or uncoding/down coding issues

Missing or incorrect date of service

 Dates of service on the claim does not match the date in the medical record

Incorrect number of units

 Documentation does not support the number of units billed on the claim

Lack of medical necessity

 Documentation does not support the medical necessity of the service provided

Duplicate Billing

 Same service is billed more than once for the same beneficiary on the same date