How to Respond to a Request for Records

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The number of records requests is increasing at a fairly constant rate and I expect it to increase more rapidly after the implementation of ICD-10. It is more important than ever to respond properly to these requests. With that in mind, I have put together these recommendations on how to best respond to a records request.

1. **Don't ignore the request.** Somehow many doctors have gotten the idea that if you don't send in any records they cannot hurt you. This is absolutely not the case. The number one reason for the denial of claims is that the "provided documentation does not support medical necessity." Many times at least half of those findings are because no records were provided. Failure to respond to a request for records hurts you, the individual doctor, and the profession as a whole.

2. **Do not alter the records.** By this I mean do not add anything to the records and do not omit anything from the records. What you have is what you have. Alteration of medical records by adding or omitting information is usually considered a fraudulent act.

3. **Make sure that the records are readable.** Records that are hand written and loaded with abbreviations are, in the best of circumstances, hard to read. Most of the time they are completely unreadable. If the reviewer cannot read the records the claim will be denied. If this is the case, it is appropriate to transcribe and translate the records. This means that you translate the abbreviations into full text and transcribe the written notes into narrative format on a word processer. It is very important to note that you cannot add and substantive information to the record. You just take the information that is there and put it into a more readable format.

4. **Make sure the record is complete.** If you left out information that you have in another area (such as an x-ray report of an outcome assessment) you can make a late entry to the note. The entry would look something like this; "Late entry to <date of original entry> added on <date of late entry>. <Signed and dated by person making entry>." This should not be common in your notes but is allowable on occasion. This is only for information that is written down but did not make it into the original note.

5. **Include sufficient information to prove medical necessity.** Most third party payers, and most especially Medicare, consider functional improvement to be proof of medical necessity for care. You will want to include records for the examination before and after the date requested to prove the patient's "starting condition" and their "finishing condition". Including this information will give a more complete picture of what has happened to the patient as a result of your care.

6. **The doctor needs to review the file before it is sent to the requester.** While much of the information in response to a records request can be prepared by your staff, it is vitally important that the doctor review the information before it is sent. The doctor is the one who is ultimately responsible.

This should give you what you need to prepare information to comply with a records request. Should you require a more detailed consultation, Dr. Short can be contacted at chiromedicare@gmail.com.