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How Medical Documentation Can Help or Hurt for Reimbursement

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The 2018 CERT report estimates 58 percent of Medicare improper payments were caused by insufficient documentation **(and this is an ongoing trend).** More than half is not something that should be dismissed, especially when you consider that those documentation problems could lead to having to repay Medicare or having to spend time working on underpayments. Here's a quick look at the top issues and a reminder about how having adequate documentation from the get-go is important to efficient billing.

Which Documentation Category Caused Most Problems

According to the Comprehensive Error Rate Testing (CERT) 2018 Medicare Fee-for-Service Supplemental Improper Payment Data, the 58 percent is based on overall Medicare results, but we'll focus here on Part B. (By the way, the 2018 report is based on a selection of claims submitted July 1, 2016, to June 30, 2017, to allow time for submission and analysis.)

For Part B, the items below were the top root causes for insufficient documentation errors. They're in order with the top one being the biggest offender. In each case, the listed item was not submitted:

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- Documentation to support medical necessity
- Valid provider's order, or element of an order
- Valid provider's intent to order (applies to certain services)
- Documentation to show that services were provided (or provided as billed)
- Documentation of a diagnostic or lab test result
- Signature log of medical personnel to ID an illegible signature or provider's written attestation about an unsigned or illegible signature.

Get Everyone on the Same Page About Complete Documentation

Some people may find it tempting to continue to cut corners on documentation because these sorts of issues may be discovered only if a claim happens to get reviewed at a level that requires submission of the medical record. But the consequences of that approach can be costly, from time spent on rework to the possibility of further audits and legal penalties. So for a little motivation, consider these points:

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- If maximizing reimbursement is a concern (and of course it is), following the correct procedures to ensure each claim gets processed and paid correctly is essential. That includes having documentation that, for instance, shows the service was provided. That allows the coder to choose the correct code and to support that coding to payers, if necessary.
- For certain procedures, payers require you to submit documentation before they decide on payment. You want to be sure your original documentation can stand up to this scrutiny, including medical necessity for the specific service provided. If the original documentation isn't sufficient, then the result may be reduced payment or no payment. And it's worth considering that the team, including the clinician who provided the service and the coders and billers involved, will have to spend time on rework, taking them away from other tasks.
- Practices need to use templates wisely. Using copy and paste can lead to mistakenly including information that does not apply to a particular patient. Going on auto-pilot for documentation may also lead to errors like forgetting to include orders for a specific patient. From the payment perspective, case-specific documentation can help support faster reimbursement because payers who request documentation will get what they need the first time without asking you to submit more information.