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FACT SHEET
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Complying with Medical Record Documentation Requirements

What's Changed?

- Added documentation guidelines for medical services (page 3)
- Added additional resources for Medicare documentation requirements (page 3)

Substantive content changes are in dark red.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

This fact sheet describes common Comprehensive Error Rate Testing (CERT) program errors related to medical record documentation. It's designed to help providers understand how to provide accurate and supportive medical record documentation.

CMS uses the CERT program to measure improper payments in the Medicare Fee-for-Service (FFS) Program. Under CERT, we review a random sample of Medicare FFS claims to determine if we paid them correctly under Medicare coverage, coding, and billing rules.

Once the CERT program identifies a claim in the sample, it requests (via fax, letter, or phone call) the associated medical records and other related documentation from the provider or supplier who submitted the claim. CERT medical review professionals then examine the claim and related documentation.

Submit enough documentation to support your claims.

Third-Party Additional Documentation Requests

When CERT requests a review, the billing provider must get supporting documentation (for example, physician's order or notes to support medical necessity) from a referring physician's office or from an inpatient facility, skilled nursing facility, or other location where records (for example, progress notes) are kept to support the services billed, ordered, or provided. The Medicare Program Integrity Manual, Chapter 3, section 3.2.3.3 has more information.

The billing provider should submit the requested documentation because they're the entity whose payment CERT reviews.

We pay for services when the medical record documentation supports Medicare coverage, coding, and billing requirements. Instruct medical record staff and third-party medical record copy services to provide all records that support payment. This may include records for services before the date of services listed on the medical record request. Examples include:

- A signed office note from a previous visit where the provider ordered a diagnostic or other service
- For "incident to" services, the care plan written by the supervising physician or non-physician practitioner (NPP)
- Lab orders for recurring tests to meet the specific needs of an individual patient

Additional Documentation Request has more information about medical reviews.

Documentation Guidelines for Medical Services

We can deny payment for services with incomplete or illegible records. For a claim to be valid, the provider's or hospital's records must have sufficient documentation to verify the services performed were compliant with all CMS policies and required the level of care billed. If there's no documentation or insufficient documentation, then there's no justification for the services or level of care billed. Also, if providers don't include sufficient documentation on claims we've already paid, we may consider the payment an overpayment, which we can partially or fully recover.

Documentation Requirements

As part of our burden reduction efforts, we've simplified some requirements so you can spend less time on paperwork. Learn more about recent changes at Simplifying Documentation Requirements and find a link to past changes.

Insufficient Documentation Errors

CERT reviewers determine claims have errors when the medical documentation submitted is insufficient to support Medicare payment for the services billed (in other words, the reviewer couldn't determine whether some of the allowed services were actually provided, were provided at the level billed, or were medically necessary).

Reviewers also place claims into this category when a specific documentation element that's required as a condition of coverage and payment (for example, statute, regulation, National Coverage Determination, or Local Coverage Determination) is missing, like a physician signature on an order, or a form that's not entirely completed.

CERT identifies insufficient documentation errors that may include:

- Incomplete progress notes (for example, insufficient detail to support you provided the service according to coverage requirements)
- Medical records that fail to demonstrate authenticity or otherwise meet a signature requirement for payment (examples: no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer)
- No documentation of order or intent to order services and procedures if required by Medicare policy

Complying with Medicare Signature Requirements has more information.

Common Procedures with Insufficient Documentation Errors

Some common categories of procedures that often result in insufficient documentation errors and more resources are summarized below.

Note: Medicare Provider Compliance Tips also lists more tips to help you order and bill items and services for your eligible Medicare patients and meet medical necessity requirements.

Physical Therapy Services

CERT identified the documentation submitted by the physician or NPP didn't support certification of the plan of care (POC). We require the physician's or NPP's signature and date of certification of the POC or progress note indicating they reviewed and approved the POC.

Complying with Outpatient Rehabilitation Therapy Documentation Requirements, the Medicare Benefit Policy Manual, Chapter 15, section 220, and Medicare Provider Compliance Tips have more information on documentation requirements for physical therapy.

Evaluation & Management (E/M) Services

CERT identified office visits (established), hospital (initial), and hospital (subsequent) as the top 3 errors in E/M service categories. High errors included insufficient documentation, medical necessity, and incorrect coding of E/M services to support medical necessity and accurate billing of those services.

The Medicare Claims Processing Manual, Chapter 12, section 30.6, Evaluation and Management Services Guide, and Medicare Provider Compliance Tips have more information on E/M documentation requirements.

We also provide more information on documentation requirements for clinicians working with trainees in Guidelines for Teaching Physicians, Interns & Residents.

Diagnostic Tests

CERT identified there was insufficient documentation to support medical necessity in the plan or intent to order diagnostic tests. If the handwritten signature is illegible, include a signature log.

The Medicare Benefit Policy Manual, Chapter 15, section 80.6, Complying with Documentation Requirements for Lab Services, and Medicare Provider Compliance Tips have more information on documentation requirements for ordering and following orders for diagnostic tests.

DME

Documentation requirements apply to certain DME items (like hospital beds, glucose monitors, and manual wheelchairs). All claims billed to Medicare require a written order or prescription from the treating practitioner as a condition for payment, which must meet standard written order requirements.

Medicare Provider Compliance Tips has more information on documentation requirements for DME.

Resources

- Medicare Coverage Database
- Provider Compliance

The Medicare Learning Network® and the Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Outreach & Education Task Force developed this content to provide nationally consistent education to health care providers.

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