WPS GOVERNMENT HEALTH ADMINISTRATORS

Tips to Avoid Improper Payment(s) Due to Insufficient Documentation

According to the CMS Medicare Fee-For-Service (MFFS) 2014 Improper Payments Report, the most common cause of improper payments (accounting for 60.1 percent of total improper payments) was lack of documentation to support the services or supplies billed to Medicare.

Claims are determined to have insufficient documentation errors when the medical documentation submitted is inadequate to support payment for the services billed (that is, the reviewer could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary). Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

The national improper payment rate attributed for insufficient documentation increased from 6.1% reported for the 2013 report period to 8.2% for the 2014 report period. Insufficient documentation accounted for the greatest proportion of improper payments, projected at $29.49 billion, for claims reviewed for the 2014 report period. The 2014 report, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2014ImproperPaymentsReport.pdf, includes tables that illustrate the projected improper payments (dollars in billions) by type of error and clinical setting, the top 10 states with projected improper payments, improper payment rates and amounts by state, and other information.

CMS and its contractors have established corrective actions to target insufficient documentation and providers and staff should also consider doing so. In addition to documenting completely and appropriately, here are some tips that providers and staff may consider:

- Make sure that both sides of double sided documents are submitted
- Ensure the documentation has legible signatures and dates
- Ensure the correct CPT/HCPCS code is used
- Ensure dates are correct and consistent with the documentation
- Ensure the provider on the documentation is consistent with the provider on the claim
- Ensure that the physician orders include an actual order or the progress note that supports the intent that the service(s) be performed as this documentation is used by the review entity to determine medical necessity
- When referring to a previous encounter in the patient's chart, include and send that documentation also

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- Include test results and lab results, if applicable
- Make certain the copy sent to the review contractor is legible; consider using a signature log
- Make certain to read the entire request for records to determine that all needed information is being sent
- For other than orders, consider sending an attestation statement when the records are not signed by the author of the medical record entry
- Include a list of acronyms if using uncommon acronyms
- Number the pages before making a copy, so it will be easy to see if one of the pages are missing
- When responding to requests for documentation, become familiar with Local Coverage Determinations or CMS Internet-Only Manual instructions that may govern the service(s) in order to return all required documentation to the requestor
- Consider establishing a point person (i.e., a Manager or Administrator) who is responsible for oversight of the collection, review, and return of records and communicate within the organization the responsibilities of this individual
    - This individual will log, document, and ensure proper processing to adhere to timeliness standards
- Use a checklist to ensure that all of the essential pieces are included in the record (the Additional Documentation Request (ADR) letter from Medicare will list the items that are necessary)
- Recognize that a rendering physician may need to obtain documentation from the ordering physician in order to send needed documentation to a CMS review entity
    - If necessary, check with the review entity as to how to document refusal of the ordering provider to provide the documentation
- Remember, it is the billing provider's responsibility to obtain the necessary information required for the record review, regardless of the location of the documentation
- Establish a line of communication between all office staff in order to determine expectations/responsibilities for timely provision of records
- Ensure complete and timely entry of documentation into the medical record
- Be aware of documentation maintenance requirements
    - CMS has published Medicare Learning Network Matters Number MM9112 that describes this. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9112.pdf
- For CMS Secure Net Access Portal (C-SNAP) users, review information available on C-SNAP to determine records previously sent and only send additional documentation